

7008 St. Rt. 88, Ravenna, OH 44266

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Age: \_\_\_\_\_

SS# \_\_\_\_\_ Medicaid # \_\_\_\_\_

Legal Guardian (if applicable): \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_

Preferred Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_

Specialist: \_\_\_\_\_ Phone: \_\_\_\_\_

Specialist: \_\_\_\_\_ Phone: \_\_\_\_\_

Specialist: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_

Insurance other than Medicare/Medicaid: YES NO

If yes, company name: \_\_\_\_\_

### EMERGENCY CONTACTS

Emergency Contact #1 \_\_\_\_\_ Relationship: \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_

Cell # \_\_\_\_\_ Other # \_\_\_\_\_

Emergency Contact #2 \_\_\_\_\_ Relationship: \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_

Cell # \_\_\_\_\_ Other # \_\_\_\_\_

What will make the first day be more interesting/successful (client likes, dislikes, activities, interests)?

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Ambulation:    \_\_\_ None        \_\_\_ Wheelchair        \_\_\_ Walker        \_\_\_ Cane

\_\_\_ Hands-on or close assistance (describe): \_\_\_\_\_

Transfer:        \_\_\_ None

\_\_\_ Hands-on or close assistance (describe): \_\_\_\_\_

Toileting:    \_\_\_ None        \_\_\_ Needs to be reminded        \_\_\_ Needs to be taken

\_\_\_ Continent        \_\_\_ Incontinent (bring products with change of clothes)

\_\_\_ Hands-on or verbal assistance (describe) \_\_\_\_\_

Diet/Eating:   \_\_\_ None        \_\_\_ Diabetic

\_\_\_ Dietary restrictions (describe) \_\_\_\_\_

\_\_\_ Chewing difficulty        \_\_\_ Choking risk

\_\_\_ Hands-on or verbal assistance (describe) \_\_\_\_\_

Communication \_\_\_ None        \_\_\_ Speech difficulty (describe) \_\_\_\_\_

\_\_\_ Memory loss (describe) \_\_\_\_\_

\_\_\_ Confusion (describe) \_\_\_\_\_

Physical problems that may restrict activities: \_\_\_\_\_

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Can this person stay at home alone? \_\_\_ YES    \_\_\_ NO

If so, how long can they stay alone safely?

\_\_\_ ½ hour or less    \_\_\_ between ½ hour and 1 hour    \_\_\_ more than 1 hour

List any allergies: \_\_\_\_\_

Date of last known Tetnus vaccine: \_\_\_\_\_

