HOME CARE INTAKE FORM

Email Confidentiality Notice: The information contained in this form is privileged and confidential and/or protected health information and may be subject to protection under the law, including the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA). **Please email to info@horizoncarepartners.com**
When anticipating discharge from a facility, PLEASE DO NOT SEND PRIOR TO THE DISCHARGE DATE.

Form Completed By

Name & Title

Address

Phone E-Mail

Date Completed Relationship to Client

Client Information

Name Phone

Address Date Of Birth D D M M Y Y

Alert & Oriented? Yes No

Lives Alone? Yes No

Martial Status S M W D

Smokes? Yes No

Cats? Yes No

Housing Type OWNS RENT HOUSE APT CONDO

Client's Emergency Contact

Name

Address

Phone Relationship to Client

Health Insurance

Medicare/Medicaid Yes No Private Pay Yes No PCP Name

Medicare/Medicaid #

PCP Phone Hospital Admission in the last 90 days? Yes No

Location of Admission Dates:

Reason for Admission

Rehab After Hospital? Yes No Which Facility

Discharge Date VNA? Yes No If Yes, Which VNA

Medical History(may include discharge summary/meds and diagnoses)

Is client aware of the referral? Yes No If no,why not?

Call client to complete referral? Yes No If no,whom should we contact? Name

Relationship

Services Requested (circle all that apply)

Geriatric Care
Private Nursing

Skilled Nursing
School Nursing

Transportation
GAPP

Patient Care Transfers
Innovative Care

Companion Care
Personal Care Assistant