

**GERIATRIC INTAKE ASSESSMENT FORM- HOUSECALLS**

(Fax form: 617-499-8354 or

Mail: Norine Philipp 1493 Cambridge Street Cambridge, MA 02139)

**I. PATIENT INFORMATION**

NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ APT # \_\_\_\_\_

PHONE #: \_\_\_\_\_ M / F S/M/Wid/Div/Sep

DESCRIPTION OF HOME: (Elderly, walk-up, elevator, etc) \_\_\_\_\_

AGE: \_\_\_\_\_ DOB: \_\_\_\_\_

MEDICARE #: \_\_\_\_\_ MEDICAID #: \_\_\_\_\_

OTHER INSURANCE: \_\_\_\_\_

LIVES ALONE: Y / N LIVES WITH: \_\_\_\_\_

LANGUAGE: \_\_\_\_\_ INTERPRETER Y / N \_\_\_\_\_

NEXT OF KIN: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ PHONE #: \_\_\_\_\_

Medical/Surgical/Psychiatric History	Current Medications	Allergies
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MD/NP Name: \_\_\_\_\_ Last vist date: \_\_\_\_\_

Doctor aware of referral? Y / N

Hospital: \_\_\_\_\_ Last Admission date: \_\_\_\_\_

Has the patient ever attended Day Care? Y/N Where: \_\_\_\_\_

Referral Source: \_\_\_\_\_ Phone #: \_\_\_\_\_

Reason for referral:

\_\_\_\_\_  
\_\_\_\_\_

**IS THE PATIENT INDEPENDENT OR DEPENDENT WITH THE FOLLOWING:**

(If dependent, who helps?) I= Independent D = Dependent

<u>ADLs</u>	<u>I</u>	<u>D</u>	<u>IADLS</u>	<u>I</u>	<u>D</u>
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	Medications	<input type="checkbox"/>	<input type="checkbox"/>
Grooming	<input type="checkbox"/>	<input type="checkbox"/>	Cooking	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	Shopping	<input type="checkbox"/>	<input type="checkbox"/>
Transfers	<input type="checkbox"/>	<input type="checkbox"/>	Finances	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	Laundry	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	Housekeeping	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>			

Is the patient continent: Bowel Y / N

Bladder Y / N

Impairments:

	<u>Impaired</u>	<u>Normal</u>	<u>Explanation of impairment</u>
Speech	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sight	<input type="checkbox"/>	<input type="checkbox"/>	_____
Orientation	<input type="checkbox"/>	<input type="checkbox"/>	_____

**II. FORMAL HOME SUPPORTS** (Please indicate which agencies provide care)

<u>Agency</u>	<u>Service</u>	<u>Contact Person (if known)</u>
<i>Somerville-Cambridge Elder Services</i>	Meals on Wheels	<input type="checkbox"/>
	Homemaker	<input type="checkbox"/> _____
	PCA	<input type="checkbox"/>
<i>VNA</i>	RN	<input type="checkbox"/> _____
	PT	<input type="checkbox"/> _____
	OT	<input type="checkbox"/> _____
	Social Work	<input type="checkbox"/> _____
	Home Health Aide	<input type="checkbox"/> _____
<i>Geri Pysch</i>		<input type="checkbox"/> _____

**Types of Durable Medical Equipment used**

**DME Company**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_