Caroline Medical Adult Day Services - Demographics and Intake

Name: _____ Nickname: _____
Address: _____
Telephone No.:_____ Cell No.: _____ Email: _____

Date of Birth	
Social Security #	
Medicare #	
Medical Assistance	Waiver
CODE STATUS	
Veteran	ADC Approved

CLIENT PHOTO

EMERGENCY CONTACTS

Name	Relationship	Phone #'s and/or email address

PHYSICIANS – please note Primary Physician

Name	Address and Telephone No. and Fax No.	Specialty

DIAGNOSIS

ALLERGIES:
HISTORY OF:
SURGERIES:
DIET Regular ☐ Pureed ☐ Thickett ☐ OTHER:

MEDICATIONS – Pillbox YES ☐ NO ☐ Pharmacy: _____

Medication Dosage and Frequency	Medication Dosage and Frequency

Name: _____

Responsible Party		Email:
Telephone # Cell#:		
Bill to:		
POA: Type of POA		
Telephone # Cell#: Email: Telephone # Cell#:		

Race/culture	
Gender	
Food Stamp Number	(9 digit number)
MA Case Worker	Telephone # Fax #
Other Services	MACP ☐ Senior Care ☐ Mental Health ☐ APS ☐ MEAP ☐
Long Term Care Insurance	
Life Insurance/Burial Account	
DDA – Resource Coordinator	
Other	

Transported by: _____ Days Scheduled: M ☐ T ☐ W ☐ Th ☐ F ☐ No. in Home _____
Please check all that apply: Walker ☐ Wheelchair ☐ Cane ☐ Assist of 1 ☐ Scooter ☐
Directions to home: _____

Release of Information – Approved

Name	***Relation***	***Phone # 1***	***Phone # 2***

OTHER PERTINENT INFORMATION: _____

_____

FOR OFFICE USE ONLY
SOC: _____ Client ID#: _____

Referral Source:_____ Date of Referral:_____