LOVEMOST CARE

HOMECARE INTAKE

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 kindly send through email, Whatsapp, Text message (862-339-8779) (lovemostcare@gmail.com) with an appropriate cover sheet.***

Gray sections are optional, all other sections are required. ***OT SEND PRIOR TO THE DISCHARGE DATE.***

FORM COMPLETED BY:		
NAME & TITLE:	PHONE:	
ADDRESS:	EMAIL:	
	FAX:	
	DATE COMPLETED:	
RELATIONSHIP TO CONSUMER:		
CONSUMER INFORMATION:		
NAME:	PHONE:	
ADDRESS:	DOB:	
ALERT & ORIENTED: ☐YES ☐NO	LIVES ALONE: ☐YES ☐NO	
MARITAL STATUS: ☐S ☐M ☐W ☐D	HOUSING TYPE: ☐OWNS ☐RENT ☐HOUSE ☐CONDO ☐APT HOUSING AUTHORITY:	
SMOKES: ☐YES ☐NO	CATS: ☐YES ☐NO	
CONSUMER'S EMERGENCY CONTACT		
NAME:	PHONE:	
ADDRESS:	RELATIONSHIP TO CONSUMER:	
HEALTH INSURANCE:		
MEDICARE: ☐YES ☐NO	MASSHEALTH: ☐YES ☐NO NUMBER:	
PCP NAME:	PCP PHONE:	
HOSPITAL ADMISSION IN LAST 90 DAYS? ☐YES ☐NO	WHERE:	DATES:
REASON FOR ADMISSION:		
REHAB AFTER HOSPITAL: ☐YES ☐NO	WHICH FACILITY:	
DISCHARGE DATE:	VNA: ☐YES ☐NO WHICH VNA?	
MEDICAL HISTORY *(may include discharge summary/meds)*:		
IS CONSUMER AWARE OF THE REFERRAL? ☐YES ☐NO	IF NO, WHY NOT?	
CALL THE CONSUMER TO COMPLETE REFERRAL? ☐YES ☐NO		
IF NO, WHOM SHOULD WE CONTACT?		
NAME:	PHONE:	
RELATIONSHIP:		
SERVICES REQUESTED:		
☐HM ☐HDMs ☐PC ☐MEAL PREP ☐MONEY MGMT ☐LAUNDRY ☐SHOPPING ☐COMPANION		
FAMILY CAREGIVER SUPPORT GROUP? ☐YES ☐NO	OPTIONS COUNSELING? ☐YES ☐NO	

Please attach additional comments, as appropriate
PLEASE DO NOT SEND PRIOR TO THE DISCHARGE DATE