SR HOMECARE OF NY

INTAKE-REFERRAL SHEET

PATIENT INFORMATION		
Date :	◉ New ◉ Re-Admission ◉ Other ( )	
Referral Taken By :	Member ID:	
Medicaid ID # :	MLTC Plan :	
Last Name :	First Name :	DOB :
		Sex : ○ Male ◉ Female ○ Other
Address :		Phone # :
Emergency Contact: (Relation) (Address)	(Home Phone)	(Work Phone)
Primary Physician :	Phone No. :	
Primary Caregiver :	Phone No. :	
Other agencies involved :	Phone No. :	
Hospitalization (Facility) :	From :	To :

MEDICAL HISTORY		
Diagnosis :		
Medications :		
Medication management : ◉ Self ◉ Family ◉ Other ( )		
Diet :	Allergies :	
Mental Status : ☐ Alert ☐ Oriented ☐ Confused ☐ Forgetful ☐ Disoriented		

CARE NEEDS		
FUNCTIONAL LIMITATIONS	**PERSONAL CARE/ADLs**	**IADLs**
☐ Speech ☐ Hearing ☐ Vision	☐ Bathing	☐ Grocery Shopping
☐ Ambulation/Mobility	☐ Transfer	☐ Errands
☐ Bedbound	☐ Grooming	☐ Banking
☐ Incontinence ☐ Bowel ☐ Bladder	☐ Ambulation/Mobility	☐ Lt. Housekeeping
☐ Cannot be left alone	☐ Dressing	☐ Laundry
☐ Equipment	☐ Meal Preparation	☐ Other :
☐ Other :		

ENVIRONMENT		
LIVING	**HOME**	**Note**
Pet : ☐ Cat ☐ Dog ☐ Other	◉ Private Home ◉ Apartment	
Smoking : ◉ Yes ◉ No	◉ Other ( )	
Lives With : ☐ Spouse ☐ Children	◉ Walk-up ○ Elevator	

OFFICE USE ONLY

SOC Requested:

Decision to Admit: ◉ Yes (SOC:) ○ No (Reason:)

RN Signature: Date:

Name: