



*ElderCare*  
RESOURCES, INC.

## Consultation Request

Your information:

Your name: \_\_\_\_\_

Your phone number: \_\_\_\_\_

your e-mail address \_\_\_\_\_

Your relation to potential client \_\_\_\_\_

Person who will be receiving services (the elder or disabled person):

Name: \_\_\_\_\_ Age: \_\_\_\_\_

Major medical needs: \_\_\_\_\_  
\_\_\_\_\_

Living situation (check all that apply):

- |                                  |   |  |
|----------------------------------|---|--|
| <input type="checkbox"/> at home | <input type="checkbox"/> with spouse      | <input type="checkbox"/> in assisted living facility |
| <input type="checkbox"/> alone   | <input type="checkbox"/> with relative(s) | <input type="checkbox"/> in residential care         |
| <input type="checkbox"/> w/ pets | <input type="checkbox"/> in memory care   | <input type="checkbox"/> in nursing care facility    |

Issues of concern (check all that apply):

- |  |   |
|--|---|
| <input type="checkbox"/> medication management | <input type="checkbox"/> checkbook management                       |
| <input type="checkbox"/> self care             | <input type="checkbox"/> mood (sadness, anger, etc)                 |
| <input type="checkbox"/> bathing self          | <input type="checkbox"/> recent or upcoming hospitalization         |
| <input type="checkbox"/> dressing self         | <input type="checkbox"/> medical transportation                     |
| <input type="checkbox"/> cooking, eating       | <input type="checkbox"/> complex medical needs                      |
| <input type="checkbox"/> shopping              | <input type="checkbox"/> need to sell home/real estate              |
| <input type="checkbox"/> wandering; safety     | <input type="checkbox"/> move to a retirement home or care facility |
| <input type="checkbox"/> guardianship          | <input type="checkbox"/> Fiduciary or estate rep                    |
| <input type="checkbox"/> conservatorship       | <input type="checkbox"/> trustee, successor trustee                 |
| <input type="checkbox"/> other: _____          | <input type="checkbox"/> estate representative                      |
| <input type="checkbox"/> other: _____          | <input type="checkbox"/> health care representative                 |
| <input type="checkbox"/> other: _____          | <input type="checkbox"/> power-of-attorney                          |