FOR OFFICE USE ONLY:

Staff Contact: _____ Contract Completed: **Y N** Notes: ______________________________

Quoted: $_____ Consult ___(office) ___ (@ _________ site); $____ KIT; Mileage: _________

Travel time: _____; Time > 1 hr. ($95): _____; Paid by: _______________ Date: __________

Active _____ JIC _____ One-time _____ Follow up: _________________________________

Client Name (Last, First): ____________________ Date: ____________________

Client Information

Client Name: ____

Client lives _____ alone; _____with (name/relation): ______________________________;

_____ with pet ____ (name/type);

_____ at ____ Care Community.

Address: ____

Client Email: ____________________________________ **Phone:** ________________

Gender designation: ____________ **DOB:** ____________ SS # ____________________

Caller Name: ___________________________________ **Relation:** _________________

Email: ____ **Phone:** ________________

Primary Support Name: _________________________ **Relation:** ________________

Address: ____

Email: ____ **Phone:** ________________

Client's Primary Concerns (Daily Living, Financial, Health, Housing, Legal, Safety, Abuse, etc.):

____

____

____

____

Client Name: ______________________________

Client's Diagnoses: ______________________________

____

Allergies (medications, other): ______________________________

Primary Practitioner Name: ____________________ Phone: __________

Clinic/Address: ______________________________

Other Practitioner Name: ____________________ Phone: __________

Clinic/Address: ____________________ Specialty: __________

Medicare #: ______________ Effective dates Part A: ________ Part B: ________

Other Insurance Company (or Medicare Supplement): ____________________

Address: ______________________________

Group/ID #s: ____________________ Phone: __________

Prescription Insurance Company Name: ____________________

Address: ______________________________

Group/ID #s: ____________________ Phone: __________

Attorney: ____________________ Phone: __________

Address: ____________________ Practice: Elder Estate

Advance Directive: Y N Where kept: ____________________

Health Care Rep.: ____________________ Phone: __________

POLST: Y N Where kept: ____________________

Guardian: ____________________ Phone: __________

Financial POA: ____________________ Phone: __________

Conservator: ____________________ Phone: __________

Referred by: ______________________________

Other Information: ______________________________