Son-Grace Inc.

T/A

Blessed Hope Home Care Services

Empowerment…Independence…Rehabilitation

INITIAL INTAKE FORM *(DDA)*

Circle program(s) for which application is being submitted

Residential ALU *CSLA* *Personal Supports* *Respite*

Applicant Name _____

Last First MI

Current Address: _____

Street City State Zip

Home Phone: _____ _____ Work Phone: _____ _____

Date of Birth: _____ (MM/DD/YYYY) Social Security #: _____

MA#: _____ SSI: _____/per month.

Age: _____ Sex: _____ Marital Status: _____ Race: _____

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Diagnosis: _____

_____

_____ Age Onset: _____

Axis I: _____ Axis II: _____ Axis III: _____ Axis IV: _____ Axis V: _____

Matrix ___ /___ Height: _____ Weight: _____

Does Applicant self-medicate? _____ YES _____ NO

Does Applicant have a **Behavior Plan**? _____YES _____NO

Skill level quoted (circle one): **HHA CNA GNA CMT LPN RN**

MEDICAL INFORMATION

Current Medications: _____

_____

_____

SEIZURES: Seizure Type: _____ Frequency: _____ medically controlled? _____

Applicant Walks: _____ Cane: _____ Crutches: _____ Wheelchair: _____

VISION: Legally Blind: _____ Glasses: _____ Last Eye Exam? _____

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ALLERGIES: _____ (dust, mold, food etc.)

Primary Health Care Provider/Physician: _____

Address: _____ Phone: _____

Home Hospital? _____ Date of last Physical Exam: _____

Provider 1 Name: _____ Service: _____

Location: _____

Phone: _____ Fax: _____

****

Provider 2 Name: _____ Service: _____

Location: _____

Phone: _____ Fax: _____

****

Provider 3 Name: _____ Service: _____

Location: _____

Phone: _____ Fax: _____

****

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Other Providers: _____

_____

_____

_____

Additional Health Information: _____

_____

_____

_____

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7122 Harford Rd Suite 2* Parkville, MD 21234* (410) 444 8133* fax: (410) 444 5685*

PHYSICIAN MEDICATION ORDER FORM

Name: _____ Diagnosis: _____

_____

Address: _____

Allergy: _____Diet: _____ Adaptive Device(s)_____

Please list all Medication/ Treatment currently being taken/ordered.

Name of Medication/ Treatment					
Dosage					
Hours/Time to be given					
Method to give Medication/ Treatment					
Purpose of Medication					
Stop Date					
Possible common side effects					
Condition for which Health Care Professional must be contacted					

Healthcare Professional's Name: _____ **Signature:** _____ **Date:**____/_____/_____

Address: _____ **Phone #:** _____**Fax /email:** _____