SteppingStone Adult Day Health

Intake Form Pg. 1

CENTER: ☐ MABINI ☐ GOLDEN GATE ☒ PRESENTATION ☐ MISSION CREEK

Referral Date: ____________________ Home Visit Date ____________________

Initial Assessment Dates: 1) ________________ 2) ________________ 3) ________________

First Day of Attendance: ________________

Client Name ____

Address ____________________________ Apt # ____________ Entry Code ____________

Cross Street ____________________ Zip ______________ Phone (___) ____________________

DAH Tenant? ______________ *Include area code*

DOB	Age	Gender M F TG: FTM/MTF	Lives Alone Y N	Relationship Status M W Sep Sgl D
Race W B As Lat Oth	Ethnicity	Language	Translation? Y N	# of living children
Social Security #		Medicare #	Other Health Insur, Acct #, Phone	
Medi-Cal #		Issue Date	Vet Admin #	

SSI: Y N Income:______________ Other: ______________

Primary Physician	Address	Phone #	Fax #
Psychiatrist	Address	Phone #	Fax #

Emergency contacts	Name	Rel	Address	Phone #
1)				
2)				
Referral Source	Name	Rel	Agency/Address	Phone #

Reason for referral: ____

Presenting Problems (Per ☐ MD ☐ Participant ☐ Referral Source)

Medical/Psychiatric: Diagnoses ____

____

Last Hospitalization/Reason ____________________________ # of Hospitalization(s) past 12 mos. ___

Sees PMD how often? ____________________ Last MD visit ________ Escort to MD appts? ________

Assist w/meds? ________________________ Other info.: ________________________________

Functional Status

Amb ___ Cane _ Walker _______ /Non-Amb ____ WC Type: M E # of Fall(s) past 6 mos. _______

Transfer ____________________________ Bathing ____________________________

Toileting ____________________________ Dressing ____________________________

Eating ____________________________ Vision ____________________________

Hearing ____________________________ Managing $ ____________________________

Other info. ____

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SteppingStone Adult Day Health

Intake Form Pg. 2

Psychosocial

Alert ______________________ Oriented __________________ Motivated for ADH _________________
Depressed _________________ GDS = ____________________ Dementia __________________
Anxious ____________________ Sleep ____________________ Appetite ___________________

☐ Requires MH Screening at intake **(as needed: request records; alert MH consultant to arrange assessment)**

Circle all that apply: current psych meds, previous psych hospitalization, currently sees psychiatrist or MH counselor, hx of suicide, hx of homicide

Current Services

Case Manager ____________________ Agency ___________________ Phone (__)_________________

Name	Agency/Rel	Service	Phone

Residence Type: Hse Apt Htl B&C Oth Rent Own Other

Home Situation: Heat ____ Toilet ____ Bathtub ______ Shower ______ Grab bars ____ Stove ________
Stairs ___ # of Steps ____ Elevator _____ Trans/Access Problems ___ Rubber Mat ____ Shower Chair ___

Description of Home Environment (safety, cleanliness, etc.; specifically barriers) ____________________

____

____

Lives: Alone w/ Family Roommate Caregiver Other: ________________

Primary Caregiver _______________________ Rel ________________ Phone (__)_________________

Significant Others (children, siblings, friends) ____

____

____

____

Brief History

Birth place _____________________________________ Education: _______________________________
When did you first come to U.S./California/SF? ____
Death of spouse/significant other; When? ____
Divorce/ Separation? When? ____
Work History: ____
U.S. Citizen? ____
Religion (optional) ____
Other info. ____

____

____

DNR: Yes No
Advance Health Care Directives: Yes No
DPA for Health: Yes No **DPA for Finances**: Yes No
(We will need a copy of all above documents that are completed)

Other info.: ____

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Reason not enrolled: ____

Completed by ____ Date _______________