SENIOR CARE OF IOWA - Intake and Referral Form

FORM COMPLETED BY:	
NAME & TITLE:	PHONE:
ADDRESS:	EMAIL:
	FAX:
	DATE COMPLETED:
RELATIONSHIP TO CONSUMER:	

CONSUMER INFORMATION:	
NAME:	PHONE:
ADDRESS:	DOB:
ALERT & ORIENTED: ☐YES ☐NO	LIVES ALONE: ☐YES ☐NO
MARITAL STATUS: ☐S ☐M ☐W ☐D	HOUSING TYPE: ☐OWNS ☐RENT ☐ HOUSE ☐ CONDO ☐APT HOUSING AUTHORITY:
SMOKES: YES NO	CATS: YES NO

CONSUMER'S EMERGENCY CONTACT	
NAME:	PHONE:
ADDRESS:	RELATIONSHIP TO CONSUMER:

LONG-TERM HEALTH INSURANCE:		
☐YES ☐NO	PRIVATE PAY: ☐YES ☐NO	
PCP NAME:	PCP PHONE:	
HOSPITAL ADMISSION IN LAST 90 DAYS? ☐YES ☐NO	WHERE:	DATES:
REASON FOR ADMISSION:		
REHAB AFTER HOSPITAL: ☐YES ☐NO	WHICH FACILITY:	
DISCHARGE DATE:	VNA: ☐YES ☐NO WHICH VNA?	
SERVICES REQUESTED: ☐*HM* ☐*PC* ☐ *HDM* ☐ *MEAL PREP*	☐*LAUNDRY* ☐*SHOPPING/ERRANDS* ☐ *COMPANION*	

SENIOR CAREOF IOWA INTAKE FORM (REV 11/03/2021) ***Fax: 515-630-0535***	**Please attach MEDICAL HISTORY (may include discharge summary/meds):** ***PLEASE DO NOT SEND PRIOR TO THE DISCHARGE DATE***

Senior Care of Iowa
100 Euclid Ave
Des Moines, IA 50313