

CLIENT INITIAL INTAKE/SCREENING FORM

Telephone contact date: _____

How did you hear about our agency? _____

Referral Name: _____

Intake date: _____

Initial Intake documented by: _____

Initial Evaluation/Assessment Schedule:

Date	Time	Address

Personal Information

Client Name (Last, First, Middle): _____ Estimated Start Date: _____

Address: _____

Environment: House Apartment ALF RCF AFH Sr.Hsng. other: _____

Marital Status: Single Married Divorced Widowed Seperated Unkwown

Home Phone: _____ Cell: _____

Email: _____

D.O.B: _____ Age: _____ Yrs Gender: Male Female Height: _____ Weight: _____

Family/Support Contacts

Primary Support Person: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell: _____ Email: _____

Secondary Support Person: _____ Relationship: _____

Address: _____

Home Phone: _____ Cell _____ e-mail _____



EQC Home Care Agency
5128 NE 42nd Ave, Portland, OR 97217.
Office Ph: (503) 853-8551 Fax: (503) 575-2428
Nurse Ph: (503) 875-0109 or (971) 263-1891 Fax: (503)328-7990

Health Care Team:

Primary Physician: _____

Address: _____

Phone: _____ **Fax:** _____ **E-mail:** _____

Are you currently receiving Home Health Services? No Yes **Agency:** _____

Case Manager: _____ **Phone:** _____ **Fax:** _____

Are you currently using Hospice Services? No Yes

Agency: _____ **Case Manager:** _____

Phone: _____ **Fax:** _____

Recent Hospitalizations: No Yes **Hospital:** _____ **Discharge Date:** _____

Discharge Planner: _____

Diagnosis-Client Status:

Current Diagnoses(is):

Allergies/Sensitivities: _____

Special Diet? No Yes

Diet List _____

Estimated Days and Times for Services

Days	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Time:From							
Time:To							
Hours							



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Services Needed/Requested			
Personal Care Service	Independent	Needs Assistance	Dependent
Bathing			
Dressing/Undressing			
Grooming			
Bowel & Bladder Care/Toileting			
Mobility			
Eating/Feeding/Drinking			
Medication Reminding			
Mental/Cognitive-Orientation			
Medication Service			
Nursing Services, Description:			
Homemaking/Companion Services			
House Cleaning			
Laundry			
Meal Preparation			
Transportation			
Arranging Appointments			
Shopping			
Companionship/Activities			
Pet Care			
Other Service Requested, Describe			
Comment:			

Billing Information	
Name: _____	
Address: _____	
Phone: _____	Fax: _____ E-mail: _____
Address: _____	
Billing Instructions (if any): _____	



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CONSENT TO RELEASE INFORMATION

Client Name: DOB:

This signed form authorizes the following persons/agency/Organization listed below to release the following information about the person listed above to EQC Home Care Agency for the purpose of: Assessment, Evaluation, Treatment and delivery of care.

1. Notes from last office visit
2. Allergies
3. Cote Status
4. List of Diagnosis and Surgical Procedures
5. List of Medications (Routine and PRN)
6. List of Treatments
7. List of Functional Abilities and Limitations
8. Dietary Requirements
9. DME and Supplies
10. Safety Measures
11. Care plan
12. Other

Name of Person	Service	Location	Phone	Fax

Client or Legal Representative

Signature

Date

Name of Witness

Signature

Date



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INITIAL EVALUATION & CONTINUING CARE NEEDS ASSESSMENT

I. SOCIODEMOGRAPHICS

CODE STATUS: _____

A. **Name** (Last, First, Middle Initial): _____

B. **Address:** _____ C. **Phone:** _____

D. **Birthdate** _____ E. **Sex** ☐ M ☐ F F. **Marital Status** ☐ Married ☐ Single G. **Religion** ☐ Catholic ☐ Jewish H. **Admission Date** _____

☐ Separated ☐ Divorced ☐ Protestant ☐ Other

☐ Widowed ☐ Unknown ☐ Unknown

I. Race

- ☐ American Indian/Alaskan Native
☐ Asian or Pacific Islander
☐ African American ☐ Hispanic
☐ White ☐ Other ☐ Unknown

J. Education

(Highest Level Attained)

K. Employment Status

- ☐ Employed ☐ Unemployed ☐ Retired
☐ Unknown

L. Payment Method(s)

- ☐ Medicaid
☐ Private Pay ☐ Veteran Benefits
☐ LTC Insurer (specify) _____

M. Does the Client Speak English

☐ Yes ☐ No

If no, primary language: _____

II. HEALTH STATUS

A. Reason(s) for Service/Care Request(s)

B. Diagnosis(es) (Principal and Secondary)

C. Current or Recent Health Problems / Risk Factors that May Affect Care Needs

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Head Injury | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Falls / Unsteadiness |
| <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Alzheimer's / Other Dementia's | <input type="checkbox"/> Contractures | <input type="checkbox"/> Impaired Vision |
| <input type="checkbox"/> Renal Disease | <input type="checkbox"/> Parkinson's / Other | <input type="checkbox"/> Amputations | <input type="checkbox"/> Impaired Hearing |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neurodegenerative Disease | <input type="checkbox"/> Pressure Ulcer | <input type="checkbox"/> Substance Misuse: |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Psychiatric Disorder | <input type="checkbox"/> Obesity | _____ |
| <input type="checkbox"/> CVA | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Food / Fluid Intake Problem | |
| <input type="checkbox"/> PVD | <input type="checkbox"/> Toxin Exposure | <input type="checkbox"/> Medication Interactions | |
| <input type="checkbox"/> Other _____ | | | |

D. Check Those Cognitive / Behavioral Factors that May Affect Care Needs:

- | | |
|--|--|
| <input type="checkbox"/> Impaired Orientation
(unaware of person, place or time) | <input type="checkbox"/> Delusions and/or Hallucinations (perceives what does not exist; thoughts of persecution, paranoia or grandiosity) |
| <input type="checkbox"/> Impaired Memory
(forgetful to the point of being dysfunctional) | <input type="checkbox"/> Wandering (does not understand territorial constraints, leading to unsafe situations) |
| <input type="checkbox"/> Impaired Comprehension
(Difficulty in understanding spoken or written directions) | <input type="checkbox"/> Agitation (anxiety; restlessness) |
| <input type="checkbox"/> Impaired Expression
(Difficulty in communicating needs verbally or in writing) | <input type="checkbox"/> Physically Assaultive
(strikes self or other, causing dangerous condition) |
| <input type="checkbox"/> Depression
(Appears sad, helpless, hopeless; has difficulty with concentration, sleep and/or appetite) | <input type="checkbox"/> Suicidal (Hx attempts; verbalizes thoughts/plan) |
| | <input type="checkbox"/> Unusual Behavior (inappropriate verbalization; reclusiveness; hoarding) |
| | <input type="checkbox"/> Other: _____ |

E. Additional Information Regarding Client's Conditions that Affects Care Needs (social / emotional / behavioral)

--

F. Mental/Emotional Evaluation

Questions to Ask Client/Client Representative	Notes/Remarks
<p>Has the client experienced loss or change in the past year? <input type="checkbox"/> No <input type="checkbox"/> Yes.</p> <p>if yes, how is the client coping with the loss(es) or change(s)?</p>	<p>Client is lonely</p> <p>Client is bereaved</p> <p>Client has experienced loss of status</p> <p>Other: _____</p>
<p>How does the client spend his/her time in a typical day at home?</p> <p>Are his/her activities meaningful to him/her <input type="checkbox"/> No <input type="checkbox"/> Yes Or to others, or just done to pass time?</p> <p>Are there activities that the client used to engage in, that he/she misses? <input type="checkbox"/> No <input type="checkbox"/> Yes If so, what are they?</p> <p>Could the client be involved with these activities again? <input type="checkbox"/> No <input type="checkbox"/> Yes If so, how?</p>	
<p>Does the client attend or participate in any organizations, associations, church/temple/religious group? <input type="checkbox"/> No <input type="checkbox"/> Yes.</p> <p>If yes, did the client attend at one time, but does not do so now? <input type="checkbox"/> No <input type="checkbox"/> Yes.</p> <p>If yes, does he/she miss being involved with these groups? <input type="checkbox"/> No <input type="checkbox"/> Yes.</p> <p>If yes, could the client be involved with assistance? <input type="checkbox"/> No <input type="checkbox"/> Yes.</p> <p>If yes, what assistance would be required?</p>	
<p>Specify cultural/religious preferences of the client relevant to services being provided/requested (language, special food, etc.)</p>	

III. FUNCTIONAL STATUS

A. Rate client's level of Independence

(Minimal assistance defined as including the need for supervision, verbal cueing or minimal physical assistance.
Moderate assistance implies the need for physical assistance.)

A. Activities of Daily Living	Independent	Minimal Assistance	Moderate Assistance	Dependent	Assistive Device(s) Needed for Activity	B. Instrumental Activities of Daily Living	Independent	Needs Assistance	Unknown
Eating/Drinking						House Cleaning			
Bathing						Laundry			
Grooming						Meal Preparation			
Dressing						Transportation			
Toilet Use						Arranging Appointments			
Bowel Mangt						Shopping			
Bladder Mangt						Companionship/activities			
Transfer						Pet Care			
Mobility									
Check most frequent mode of locomotion: ___ Walking ___ Wheelchair						C. Additional Assistive Devices Currently in use			
						Glasses Dentures Hearing Aid Other (Specify):			

B. Communication

Comprehension
(Ability to understand auditory or visual communication)

- ___ Able to understand directions
- ___ Can follow directions with minimal prompting, repetition
- ___ Has difficulty following directions, needs constant prompting
- ___ Unable to follow simple directions

Expression
(Ability to communicate basic daily needs)

- ___ Expresses needs clearly
- ___ Expresses needs slowly or requires minimal prompting
- ___ Expresses needs with difficulty, requiring much prompting
- ___ Unable to express needs

Usual Mode(s) of Communication

- ___ Speech
- ___ Writing
- ___ Gestures / Sounds
- ___ Sign Language
- ___ Communication Device

C. List Restrictions that Would Affect Ability to Perform Above Functions:

1. _____
2. _____
3. _____
4. _____

IV. ENVIRONMENTAL FACTORS AFFECTING CONTINUING CARE

A. Living Arrangements: ☐ Own home ☐ Relative's home ☐ Rental home / Apt. ☐ Assisted Living/RCF
☐ Alone ☐ With Spouse ☐ With Others (specify relationship & names below)

Other _____

B. Environmental Barriers	Yes	No	Comments:
Are there barriers to building entry / exit?			
Are there internal barriers? (stairs, narrow doorway)			
Are toilet / tub / shower accessible?			
Is the Client able to access emergency assistance?			
Other Barriers (specify):			

V. MEDICAL HISTORY & CARE REQUIREMENTS

A. Nursing Needs:

1. Skin: ☐ Pressure Ulcer Care ☐ Wound Care
2. Nutrition: ☐ Special Diet (specify): _____
☐ Tube Feeding (Type, specify): _____
3. Hydration: ☐ Encourage Fluids ☐ Restrict Fluids
4. Respiratory: ☐ Oxygen ☐ Continuous ☐ Intermittent
☐ Tracheostomy ☐ Suctioning ☐ Ventilation
5. Elimination ☐ Urinary Catheter ☐ Ostomy
☐ Dialysis: ☐ Hemo ☐ Peritoneal ☐ CAPD Treatment Frequency: _____
6. Administration / Management of Medications:
☐ Oral ☐ Subcutaneous / Intramuscular
☐ Intravenous: ☐ Implanted Pump

Other: _____
8. Supervision / Evaluation: _____
9. Other Nursing Care Needs: _____

B. Client and/or Family and/or Client's Representative's Educational Needs:

- ☐ Self-Care Activities ☐ Self – Management of Illness ☐ Diet Instruction ☐ Medication Administration
☐ Ostomy Care ☐ Wound Care / Dressing Change ☐ Tracheostomy Care / Suctioning
☐ Other: _____

C. List of Medications

1.	5.
2.	6.
3.	7.
4.	8.

D. Allergies: _____

VI. FAMILY AND COMMUNITY SUPPORT

A. Source(s) of Support:

Primary Support	Relationship or Agency	Type of Support (physical, psychological, social and/or economic)	Availability	Limitation or Constraints	B. Community Services Utilized Prior to Admission
Name:					
Address:					
Phone:					
Other Caregiver:					
___ No Known Support					

C. Physician (PCP):

Name _____ Phone: _____

D. Other Individual Responsible for Coordinating Care:

Name _____ Phone: _____

VII. CLIENT / CLIENT'S REPRESENTATIVE'S GOALS AND PREFERENCES

A. Client's Goals and Preferences for Continuing Care:	B. Religious or Ethnic Practices that May Affect Needs or Preferences for Continuing Care:		
C. Caregiver's Preferences for Continuing Care:	E. Decision-Making Support: DNR	<u>Already Has</u>	<u>Desires / Requires</u>
	Durable Power of Attorney for Health Care Decision Making		
	Living Will		
	Guardian / Conservator		
E. Client's Representative/Surrogate Decision-Maker:			
Name _____ Phone: _____			

VIII. CONTINUING CARE NEEDS

A. Additional Service Needs that are Unavailable through this Agency:

___ Acute Nursing Care ___ Respiratory Therapy ___ Physical Therapy ___ Social Work
___ Occupational Therapy ___ Mental Health ___ Speech Therapy
___ Other: _____

B. Durable Medical Equipment / Supply Needs:

C. ☐ Hospital bed ☐ Side rails ☐ Trapeze ☐ Commode

☐ Walker ☐ Wheelchair ☐ Oxygen

☐ Other: _____

☐ Disposable Supplies: _____

C. Needs / Options Have Been Discussed with: ☐ Client; ☐ Client's Representative/Family; ☐ Not Discussed

IX. **SERVICE GOALS / ASSESSMENT CONCLUSIONS**

Admin/Designee/RN Signature: _____ Date: _____



**CLIENT'S STATEMENT OF RECEIPT OF
THE EMERGENCY SUPPLY KIT CHECK LIST &
RECOMMENDATION FROM AGENCY TO CREATE & MAINTAINING
AN EMERGENCY SUPPLY KIT**

Essential Quality Care LLC, in an effort to provide safe, appropriate and ongoing services to our clients, has recommended to _____
_____ (print name of client and/or client representative) to develop a 72-hour emergency supply kit. This document confirms that our agency has informed this client and/or client representative, of the need for such an emergency supply kit and that the client and/or client representative understands the possible consequences of not having such a kit available. This further acknowledges that our agency staff provided you with an *Emergency Supply Kit Check List*.

Client or Client's
Representative's Signature _____

Date: _____

Administrator or Designee's Signature _____

Date: _____

This document is to be filed in the client's office chart.



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**DISCLOSURE STATEMENT & CLIENT RIGHTS
ACCEPTANCE & REVIEW STATEMENT**

My signature below confirms that I have received and reviewed the Essential Quality Care's Disclosure Statement and Clients' Rights statement.

Name of Client:

Client's Signature

Date:

Name of Client's Representative (if available):

Client's Representative's
Signature:

Date:

Signature of EQC Administrator or Designee

Date

This completed page is to be detached from the disclosure statement & client's rights and kept in the client's file in the Agency's office.



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ADDITIONAL NOTES:

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