SarahCare®

Coral Springs Adult Day Care Center

Intake Assessment

Dates: Trial Day:____/____/____ Intake: ____/____/____ Assessments: ____/____/____ Start Date: ____/____/____

Name & Vital Information

Participant Name: _____ Client SSN: _____
Last First M.I. Medicare: _____
Medicaid: _____

Address: _____
Street City State Zip

Phone: (_____) _____

Demographics

Birth Date ____/____/____ Place of Birth: _____ Age: _____ Sex: ☐Male ☐Female

Marital Status: ☐ Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Single ☐ Significant Other

Preferred Hospital: _____

Primary Language: _____ Secondary Language: _____

Race: ☐ White ☐ Oriental/Asian ☐ African American ☐ Hispanic ☐ Other Ethnic Origin: _____

Religion: _____

Primary Caregiver /Emergency Contact

Emergency Contact 1: _____ (H) _____ (Cell) _____

Relationship: _____ E-Mail Address: _____

Emergency Contact 2: _____ (H) _____ (Cell) _____

Relationship: _____ E-Mail Address: _____

Emergency Contact 3: _____ (H) _____ (Cell) _____

Relationship: _____ E-Mail Address: _____

Emergency Contact 4: _____ (H) _____ (Cell) _____

Relationship: _____ E-Mail Address: _____

Primary Physician: _____ (Ph) _____ (Fax) _____

Address: _____

Insurance Co. Name: _____ Phone #: _____ Policy #: _____

Safe Return: _____ I.D. # _____

Life Line: _____