1st American Choice Home Health Care Services LLC

ADMISSION ASSESSMENT

PATIENT NAME:______________________________
ADDRESS:______________________________

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PHONE NO.:______________________________
SS NO.: ______________________________
MC NO.:______________________________
DOB: ______________ SEX: MALE / FEMALE
MD NAME:______________________________
ADDRESS:______________________________

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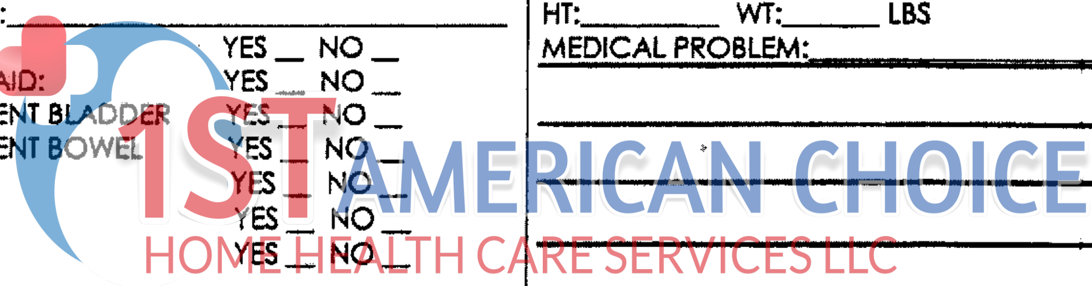
DR PHONE NO.:______________________________
ALLERGIES:______________________________



GLASSES: YES __ NO __
HEARING AID: YES __ NO __
INCONTINENT BLADDER YES __ NO __
INCONTINENT BOWEL YES __ NO __
DENTURES YES __ NO __
SMOKER YES __ NO __
DRINK YES __ NO __

MEDICATIONS:
DATE/NAME/DOSAGE/FREQUENCY

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PHARMACY NAME/NO.:

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EMERGENCY CONTACT:
NAME:______________________________
PHONE NO.:______________________________
SUPPORT SYSTEM FOR AMBULATION:
(WALKER/CANE/WC)______________________________

DATE:______________________________
DESCRIPTION OF SKIN:______________________________

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PATIENT LIVES WITH:______________________________
NAME OF CG:______________________________
PAIN: YES ___ NO ___
SITE:______________________________
FREQUENCY:______________________________

VITAL SIGNS:
T:_____P_____R_____BP___/___ BS______ F OR NF
HT:__________ WT:________ LBS
MEDICAL PROBLEM:______________________________

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REFERRALS:
SN: _____ YES _____ NO
PT: _____ YES _____ NO
OT: _____ YES _____ NO
HHA:_____ YES _____ NO
MSW:_____YES _____ NO
PROVIDER SERVICE REF:______________________________
RX ASSIST PROGRAM: ______________________________

DME (DOES PT NEED) EX: GLUCOMETER, HOSP. BED, WALKER ETC.:______________________________

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COMMENTS: