MEDICAID HOME HEALTH INTAKE WORKSHEET
60 DAY PRIOR

All areas MUST be filled in

PATIENT ID #:	DATE:
PATIENT NAME:	ADMITTING R.N.:
DOB:	PHONE #:
DR.'S NAME:	PROVIDER:
NPI #:	PROVIDER #:
IS THE CLIENT'S RESIDENCE THE MOST APPROPRIATE SETTING FOR THE REQUESTED SERVICES?	ANY LESS COSTLY ALTERNATIVE SETTINGS FOR REQUESTED SERVICES?

Assessment Date:_____

Diagnosis:_____

_____

Recent Hospitalization:_____ yes _____ no; Discharge Date:_____

Surgical Procedures:_____

Living Arrangements:_____home _____apartment_____relatives_____group home_____

Caregivers living with client or available to client_____

Functional Limitations of the client:

( )endurance ( )ambulation ( )amputation ( )respiratory
( )incontinence ( )contractures ( )paralysis ( ) mental
( )speech ( )vision ( )hearing ( )other_____

Activities Permitted:

( )bedrest ( )up as tolerated ( )transfer bed/chair ( )exercises prescribed
( )partial weight bearing ( )independent at home
( )crutches ( )walker ( )other_____
( )no restrictions ( )wheelchair

Diet:_____

Medications:

Mental Status:_____

Physicians orders for:

Skilled nurse (please include wound dimensions, if wound care is ordered) - _____

_____

_____

_____

Home health aide_____

_____

_____

Physical therapy_____

_____

Equipment in the home or needed in the home_____

_____

Other significant information_____

_____