

Participant Data Sheet

DOC: _____ Admission Date: _____ Free Day: _____

Referral Source: **ADI** **DR** **Medicaid** **Friend** **VA** **Other** _____

Participant Name: _____ Nickname: _____ Sex: Male Female

Address: _____ S.S.#: _____ - _____ - _____

City: _____ State: _____ Zip: _____ Phone #: (____) _____

Date of Birth: _____ Age: _____ Ethnicity: _____

Race: _____ Marital Status: _____ Living Situation: Assisted Living
 Home
 Home with Help
 Other

Caregiver Information:

Name: _____ Address: _____ Relationship: _____

City: _____ State: _____ Zip: _____ Email: _____

Phone Day: (____) _____ Work: (____) _____ Cell: (____) _____

Emergency Contact Information: (If same as above check here)

Name: _____ Relationship: _____

Phone Day: (____) _____ Work: (____) _____ Cell: (____) _____

Client Medical Information:

Primary Care Physician: _____ Specialty: _____

Phone: (____) _____ Fax: (____) _____

Additional Physicians: _____ Specialty: _____

Phone: (____) _____ Fax: (____) _____

- Member will need transportation
- Faxed Dr. Orders to Dr. Office _____
- Physician orders received _____
- Admission Packet given to family _____
- Financial Assistance/SRA _____
- Stand and Pivot
- Allergies _____
- Continent Incontinent Bathroom Assist
- Diabetic Dietary Restrictions
- Project Lifesaver
- Dentures Glasses Hearing Aids

Support Group
 ADC Visit
 1st _____
 2nd _____
 3rd _____