COMMUNITY INTAKE FORM

URGENCY ___/10

PLEASE PRINT: DATE: ____________________________

WHO IS COMPLETING THIS FORM? YOU ARE: INDIVIDUAL WITH ILLNESS _____ FAMILY/INFORMAL CAREGIVER _____

IF YOU ARE FAMILY/CAREGIVER WHAT IS YOUR RELATIONSHIP TO INDIVIDUAL WITH ILLNESS? ______________________________

NAME: (FIRST)____ (LAST)____

DATE OF BIRTH: (DD/MM/YY) _________________ GENDER: _____________ FAITH/RELIGION: __________________________

PHONE: ____ (ALTERNATE): ____

EMAIL: ____

HOME ADDRESS: ____ PC: _________________

CURRENT LOCATION: HOME ___ RESIDENTIAL CARE HOME ___ HOSPITAL ___ OTHER: __________________________________

LIVE ALONE _____ *YOUNG CHILDREN IN HOME* ______ *SMOKING IN HOME* ______ *PET(S)?*___________________________

EMPLOYMENT: ____ PHONE: _________________________________

ARE YOU CURRENTLY WORKING? ____

PRIMARY DIAGNOSIS: ____ DATE OF DIAGNOSIS: __________________

OTHER HEALTH ISSUES: ____

____

POWER OF ATTORNEY FOR PERSONAL CARE IF KNOWN: ____

NAME OF EMERGENCY CONTACT	RELATIONSHIP	HOME PHONE	BUSINESS/CELL #

PLEASE PROVIDE ALL PROVIDERS AND SERVICES CURRENTLY INVOLVED: (IF KNOWN)

NAME	PHONE	FAX
FAMILY PHYSICIAN:		
NURSE PRACTITIONER:		
CCAC:		
COMMUNITY NURSE: (AND AGENCY)		
OTHER:		

REFERRED BY: ____ **AGENCY:**______________________________

CONTACT INFO: ____

REFERRAL FOR REFERRAL: *(DETAILS OF SOCIAL SITUATION, INCLUDING ANY NEEDS/CONCERNS OF FAMILY)* ________________________

____

____

____

____

PLEASE TURN OVER →

PLEASE CHECK ALL SERVICES OF INTEREST:

___COMPLEMENTARY THERAPIES ___GRIEF SUPPORT ___ SELF-CARE MANAGEMENT ASSISTANCE

___ONE TO ONE SUPPORT ___GROUP SUPPORT ___OTHER (___________________________)

ARE YOU ABLE TO ATTEND APPOINTMENTS AT OUR OFFICES? ___ YES ___ NO

IF NO, WHAT IS THE REASON?____

WHAT ARE THE BEST TIMES AND DAYS AVAILABLE FOR APPOINTMENTS?

PLEASE CHECK ALL THAT APPLY

( ) MORNINGS (8-11 AM) ( ) MONDAY ( ) THURSDAY

( ) AFTERNOONS (12-4 PM) ( ) TUESDAY ( ) FRIDAY

( ) EVENINGS (5-8 PM) ( ) WEDNESDAY ( ) SATURDAY (AM OR AFTERNOON)

( ) OTHER: ____

TERMS AND CONDITIONS

Before submitting this form and utilizing the many support services of Hospice Outreach Programs of Elgin (HOPE)please read these Terms and Conditions carefully. You fully understand that ongoing use of HOPE's services indicates that you agree to the Terms and Conditions summarized below.

DISCLAIMER: SERVICES PROVIDED BY HOPE ARE NOT A SUBSTITUTE FOR MEDICAL ADVICE OR TREATMENT.

CONFIDENTIALITY: YOUR PERSONAL INFORMATION (AS ON THIS INTAKE FORM), AS WELL AS THE CONTENT OF YOUR CONSULTATION SESSIONS WITH A REPRESENTATIVE REPRESENTING HOPE, MAY BE USED IN CASE OF AN EMERGENCY SITUATION ONLY. IN ORDER TO KEEP YOU AND THE COMMUNITY SAFE: WE OFFER CONFIDENTIALITY IN OUR SESSIONS. THIS MEANS THAT WHATEVER YOU SAY IN OUR SESSION WE WILL NOT TELL OTHERS WITHOUT YOUR PERMISSION EXCEPT FOR THREE CONDITIONS:

1. *YOU HAVE A PLAN TO HARM YOURSELF OR SOMEONE ELSE. (THIS MEANS THAT YOU HAVE PLANNED OUT THE EXACT SITUATION WHERE SOMEONE CAN GET HURT, WE HAVE A DUTY TO REPORT THAT.)*
2. *YOU SHARE A PAST OR PRESENT CASE OF CHILD ABUSE THAT HAS NOT YET BEEN REPORTED.*
3. *WE GET COURT SUBPOENAED, WHICH MEANS THE COURT REQUESTS DOCUMENTS OF OUR SESSIONS WITH YOU.*

COMMUNICATION OF PRIVATE MENTAL HEALTH INFORMATION

PLEASE ***(√)*** *ALL ACCEPTABLE FORMS OF COMMUNICATION TO PROVIDE QUALITY CLIENT CARE:*

□ I AUTHORIZE HOPE'S REPRESENTATIVE TO LEAVE A MESSAGE REGARDING MY PRIVATE INFORMATION ON MY PERSONAL VOICEMAIL/ANSWERING MACHINE.

□ I AUTHORIZE HOPE'S REPRESENTATIVE TO SEND WRITTEN COMMUNICATION TO MY HOME OR EMAIL ADDRESS.

□ I AUTHORIZE HOPE'S REPRESENTATIVE TO SHARE INFORMATION WITH OTHER HEALTH CARE PROFESSIONALS I MAY BE ASSOCIATED WITH, NOW OR IN THE FUTURE, IF HELPFUL TO MY CARE.

□ BY SIGNING BELOW, I ACKNOWLEDGE THAT THE ABOVE INFORMATION IS CORRECT AND HEREBY GIVE AUTHORIZATION FOR THE RELEASE OF INFORMATION BY THE ACCEPTABLE MEANS CHECKED ABOVE.

PAYMENT: THERE IS NO CHARGE FOR OUR SERVICES. DONATIONS ARE APPRECIATED, BUT NOT REQUIRED.

SIGNED:____ **DATE:** _______________________

Client signature or Parent/Guardian signature (if client is a minor or under age 12)