A HELPING HAND

Full Service Non-Medical Agency

The Agency That Follows Through

Intake of Care

Date:_____ **Referred**_____

Name of Client:_____ **Person filling out form:**_____ **Ph.** _____

Do you want info packet sent to you? If so please indicate address below.

Address to send info_____

Number Street Name City Zip code

Medical Condition:

_____

_____

_____

Ambulatory? ❑ Yes ❑ No

w/ ❑ cane ❑ walker ❑ wheelchair ❑ Hoyer lift

Can individual help with transfers? ❑ Yes ❑ No

Personal hygiene/Homemaker:

Do you need assistance in the following areas?

❑ Oral care ❑ Bathing/Shower ❑ Incontinent care ❑ Dressing ❑ Bed bath

❑ Sponge bath ❑ Meal prep ❑ Light Housekeeping ❑ Laundry ❑ Transportation

❑ Medication remind/assist ❑ Wound dressing ❑ Light gardening

Type of service your looking for?

❑ Homemaker ❑ Skilled ❑ Pop-In visit ❑ Bath visit ❑ Sleepover

❑ Twenty four hour care (live-In) ❑ Respite care

Brief description of your needs:

_____

_____

_____

Email form and you will receive a call