Maine Medical Center

GERIATRIC CENTER INTAKE

Date: _____ Referral for (please check):Geriatric Assess. __ Memory Impairment Assess.__

Patient Name:_____

Address:_____

City, State, Zip:_____

Date of Birth:_____ Age:_____ Title (Miss; Mr; Mrs):_____ Home Tel. #:_____

Marital Status:_____ Soc. Sec. #:_____ Language: _____

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Person filling out form:_____Relation:_____

E-mail Address (for confirmation that faxed forms were received):_____

May we contact you via e-mail with information about your appointment? ____yes ____no

Person to call for Appointment: _____ Tel. #:_____

Contact Person(s): _____ Relation: _____

Address:_____

Home Phone: _____ Work Phone: _____

Contact Person(s): _____ Relation: _____

Address:_____

Home Phone: _____ Work Phone: _____

Contact Person(s): _____ Relation: _____

Address:_____

Home Phone: _____ Work Phone: _____

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Insurance – Medicare #: _____

Effective Date Part A: _____ *Effective Date Part B*: _____

Supplemental Insurance:

Company: _____ *Policy/Certificate #:*_____

Company: _____ *Policy/Certificate #:*_____

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Reason for referral to Outpatient Geriatric Center:_____

_____

Primary Care Physician: _____ Tel. #: _____

Address:_____ Fax #_____

Other Specialist: _____ Tel. #: _____

Address:_____

Other Specialist: _____ Tel. #: _____

Address:_____

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LIVING ARRANGEMENTS:

☐ Alone in own home with assistance? ☐ Yes ☐ No
☐ Alone in apartment with assistance? ☐ Yes ☐ No
☐ With family/companion/friend _____
☐ Skilled Nursing Facility _____
☐ Residential Care Facility _____
☐ Senior Housing _____
☐ Nursing Home _____
☐ Other _____

What are the most important issues/concerns facing you now, to be addressed by the Geriatric Center?

_____
_____
_____
_____

Do you have help from any agencies? Please list: _____
_____
_____
_____

Have you been in the hospital or Emergency Room recently? ☐ Yes ☐ No
Date(s): _____
Reason(s): _____
_____
_____

We would like to get information from you and someone who knows you well. Can you bring a family member of friend with you when we see you? ☐ Yes ☐ No

The visit will last several hours. Feel free to bring a snack to have during your appointment. We will send directions along with supplemental paperwork to be completed and mailed back to us before your appointment is scheduled.

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FOR OFFICE USE ONLY

OUTCOME:

☐ Patient not appropriate
☐ Patient referred to:_____
☐ Patient to be seen

COMMENTS:_____
_____
_____
_____
_____
_____

_____
Signature and title of person reviewing Intake