SteppingStone Adult Day Health

Intake Form Pg. 1

Please check a box if you have a preferred center, otherwise, please leave the boxes blank.

CENTER : ☐ GOLDEN GATE Fax 415-359-9282 ☐ MABINI Fax 415-882-7390
☐ MISSION CREEK Fax 415-974-6784 ☐ PRESENTATION Fax 415-923-0275

Please fax the Intake Form to our Intake Coordinator, Rui Yang, at 415-974-6785 or contact him at 415-974-6784 ext.23 or ruiyang@steppingstonehealth.org if you have any questions.

Referral Date: ____________________ Home Visit Date ____________________

Initial Assessment Dates: 1) ________________ 2) ________________ 3) ________________
First Day of Attendance: __________________

Client Name ____
Address ______________________________ Apt # ______________ Entry Code ______________
Cross Street _____________________ Zip _______________ Phone (___) _____________________
DAH Tenant? ______________ *Include area code*

DOB	Age	Gender M F TG: FTM/MTF	Lives Alone Y N	Relationship Status M W Sep Sgl D
Race W B As Lat Oth	Ethnicity	Language	Translation? Y N	# of living children
Social Security #		Medicare #	Other Health Insur, Acct #, Phone	
Medi-Cal #		Issue Date	Vet Admin #	

SSI: Y N Income:_____________ Other: ______________

Primary Physician	Address	Phone #	Fax #
E-mail			
Psychiatrist	Address	Phone #	Fax #
E-mail			

Emergency contacts 1)	Name	Rel	Address	Phone #
E-mail				
Emergency contacts 2)	Name	Rel	Address	Phone #
E-mail				
Referral Source	Name	Rel	Agency/Address	Phone #
E-mail				

Reason for referral: ____

Presenting Problems (Per ☐ MD ☐ Participant ☐ Referral Source)
Medical/Psychiatric: Diagnoses ____
____
Last Hospitalization/Reason ____________________________ # of Hospitalization(s) past 12 mos. ___
Sees PMD how often? ____________________ Last MD visit ________ Escort to MD appts? ________
Assist w/meds? _________________________ Other info.: ________________________________

SteppingStone Adult Day Health

Intake Form Pg. 2

Functional Status

Amb __ Cane _ Walker _______ /Non-Amb ____ WC Type: M E # of Fall(s) past 6 mos. _______
Transfer ______________________ Bathing ______________________
Toileting ______________________ Dressing ______________________
Eating ______________________ Vision ______________________
Hearing ______________________ Managing $ ______________________
Other info. ______________________

Psychosocial

Alert ____________ Oriented ____________ Motivated for ADH ____________
Depressed ____________ GDS = ____________ Dementia ____________
Anxious ____________ Sleep ____________ Appetite ____________

☐ Requires MH Screening at intake **(as needed: request records; alert MH consultant to arrange assessment)**

Circle all that apply: current psych meds, previous psych hospitalization, currently sees psychiatrist or MH counselor, hx of suicide, hx of homicide

Current Services

Case Manager ____________ Agency ____________ Phone (__)____________
E-mail ______________________ Fax (___) ____________

Name	Agency/Rel	Service	Phone

Residence Type: Hse Apt Htl B&C Oth Rent Own Other

Home Situation: Heat ____ Toilet ____ Bathtub ______ Shower ______ Grab bars ____ Stove ________
Stairs ___ # of Steps ____ Elevator _____ Trans/Access Problems ___ Rubber Mat ____ Shower Chair ___

Description of Home Environment (safety, cleanliness, etc.; specifically barriers) ____________

Lives: Alone w/ Family Roommate Caregiver Other: ____________
Primary Caregiver ____________ Rel ____________ Phone (__)____________
Significant Others (children, siblings, friends) ____________

Brief History

Birth place ____________ Education: ____________
When did you first come to U.S./California/SF? ____________
Death of spouse/significant other; When? ____________
Divorce/ Separation? When? ____________
Work History: ____________
U.S. Citizen? ____________
Religion (optional) ____________
Other info. ____________

DNR: Yes No **Advance Health Care Directives**: Yes No
DPA for Health: Yes No **DPA for Finances**: Yes No
(We will need a copy of all above documents that are completed)

Other info.: ____________

Reason not enrolled: ____________

Completed by ____________ Date ____________