

**THE CHRIST HOSPITAL PHYSICIANS**

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Today's Date: \_\_\_\_\_

Patient's Legal Name: \_\_\_\_\_  
Last First Middle Initial Date of Birth

Contacts: In the event you are incapacitated, there is an emergency, or if we are unable to reach you, are we permitted to discuss or release your health information\* to the following identified individual(s):

Yes (Complete information below)       No (Skip to the next question)

Name: _____	Name: _____
Relationship to Pt: _____	Relationship to Pt: _____
Home #: (____) _____	Home #: (____) _____
Work #: (____) _____	Work #: (____) _____
Cell #: (____) _____	Cell #: (____) _____

\*health information includes, but is not limited to: test results, prescription refills, billing questions and if needed, cases of emergency.

May we leave messages/test results on your answer machine?      Y      N

May we call you at your place of employment?      Y      N

If printed prescriptions or sample medications are needed, the following may pick up prescriptions and/or sample medications:

Name: _____	Relationship: _____
Name: _____	Relationship: _____

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)**

We are legally required to provide you with a copy of our NOTICE OF PRIVACY PRACTICES the first time you receive care at TCHP. If you are here for emergency medical treatment, you will be given a copy as soon as possible.

I received a copy of the Notice of Privacy Practices.

I have previously received a copy of the Notice of Privacy Practices.

I do not want a copy of the Notice of Privacy Practices.

\_\_\_\_\_  
SIGNATURE OF PATIENT (if 18 years or older) OR LEGAL GUARDIAN IF APPLICABLE      Date/Time

**Geriatric Assessment Intake Form**

Name of person completing this form, Relationship to patient and phone number:

\_\_\_\_\_

Patient Name: (Miss, Mrs., Mr.) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Marital Status:  Married  Single  Widowed  Divorced

Address: \_\_\_\_\_

Primary telephone: \_\_\_\_\_ Secondary telephone: \_\_\_\_\_

Language: \_\_\_\_\_ Education Level: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Secondary Insurance: \_\_\_\_\_

Do you have a living will?  YES  NO

Do you have a durable power of attorney (healthcare and/or financial) ?  YES  NO

If yes for either of these questions, please send in copies with intake forms.

What is the current living situation?

In own home, alone  With spouse  With caregiver  Assisted living facility, \_\_\_\_\_

Are there any professional or community services currently involved? (Please list contact and phone number if known): \_\_\_\_\_

Who is your primary care physician? Please list name and phone number:

\_\_\_\_\_

Do you currently see any specialists (Cardiologist, Orthopedic, Psychiatry/Mental Health, GI, Pain, etc.): \_\_\_\_\_

Have you been in the hospital or emergency room recently?  YES  NO

Hospital Name: \_\_\_\_\_

Pharmacy Name and Phone Number: \_\_\_\_\_

**Present Medications: (including over-the-counter and herbal)**

Please complete the following OR attach a current medication list

**Medication and Dosage**

**How Often**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Behavior/Mood/Memory

Quality care for older adults is best provided when there is a working partnership between the patient's physician and the caregiver. As caregiver, you are the best observer of changes in the patient which the physician needs to know about- especially, any gradual or sudden changes in the person's normal abilities, behavior, memory or mood.

What was the first change (from the his/her "usual self") that you noticed in any of these areas: Memory, behavior, mood or emotional state, ability to function independently, ability to care for him/herself and his/her living environment, and/or ability to work or engage in hobbies and interests?

\_\_\_\_\_

Approximately when did this occur? \_\_\_\_\_

\_\_\_\_\_

## Self-Care Activities

**Please check if you have noticed problems in any of the following areas**

- |                                 |                              |                             |
|---------------------------------|------------------------------|-----------------------------|
| Control of bowel and/or bladder | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Dressing                        | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Eating                          | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Grooming                        | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Cooking                         | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Driving                         | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Medications                     | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Finances                        | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

### **Does he/she have trouble remembering:**

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Things he/she has been told in the previous 5-10 minutes     | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Names of close family members                                | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| To secure home/car when vacated (turn stove off, lock doors) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Difficulty making reasonable, sound decisions                | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Difficulty understanding what he/she is told                 | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| What he/she is doing or talking about                        | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

### **Does he/she show:**

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Sadness  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Loss of interest in usual concerns/activities              | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Worry, anxiety or nervousness                              | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Anger  | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Hallucinations   | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Talking about suicide                                      | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Has withdrawn from one or more usual or enjoyed activities | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Has become lost in a familiar area                         | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

- Wanders aimlessly, especially at night  YES  NO  
Takes medication inappropriately  YES  NO  
Accuses others of stealing or doing something "bad" to him/her  YES  NO  
Engages in reckless or dangerous behavior  YES  NO  
Are any of the above symptoms gradually getting worse?  YES  NO

**Any other concerns/comments:**

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**Caregiver Questionnaire:**

**On a scale of 1 to 5 (with 5 being the most intense), how much burden are you feeling regarding your caregiving?**

1      2      3      4      5

**What else can we do to assist you in the care of this person (help with care, adult day, home care, nursing homes, support groups, other resources, etc.)?**

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# DIRECTIONS TO OUR OFFICE

## HEALTH & AGING CENTER

The Christ Hospital Health & Aging Center is located at the former site of the Oakley drive-in, just inside Carespring's Indianspring Transitional Care Center.

### BY NORTH-SOUTH ROUTE

Take the Red Bank Road exit (one-way off exit) and follow Red Bank Road to the Madison Road intersection.

Turn right on Madison Road.

Turn left at the first light into Madison Circle at Babson Place.

At the second drive, turn left again.

Take another left turn at The Plaza @ Madison Circle. The Health & Aging Center is directly inside the double-doors to the left.

### BY NORTH-SOUTH ROUTE

Take the Norwood Lateral East to the Ridge Road exit. At the light, take a right onto Ridge Road.

Follow that to the Madison Road intersection. Turn left at the light.

Turn right into Madison Circle at Babson Place.

At the second drive, turn left.

Take another left turn at The Plaza @ Madison Circle. The Health & Aging Center is directly inside the double-doors to the left.

### BY WEST-EAST ROUTE

Take Columbia Parkway to the Red Bank Road exit. Turn right off the exit.

Follow Red Bank Road to the Madison Road intersection. Take a left on Madison Road.

Turn left at the first light into Madison Circle at Babson Place.

At the second drive, turn left.

Take another left turn at The Plaza @ Madison Circle. The Health & Aging Center is directly inside the double-doors to the left.

