

**Eyerly-Ball Community Mental Health Services**  
**SENIOR OUTREACH COUNSELING/INTAKE FORM**  
Fax number: 515-277-0661 Phone: 515-277-0630

**Date:** \_\_\_\_\_

**Name:** \_\_\_\_\_ age: \_\_\_\_\_ DOB: \_\_\_\_\_

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

\_\_\_\_\_ Zip: \_\_\_\_\_ SS#: \_\_\_\_\_

Marital Status \_\_\_\_\_ Hshld. Composition \_\_\_\_\_ Type of Dwelling \_\_\_\_\_

**Problem Statement** (Include specific symptoms of mental health problems)

Expectations of Referring Agency/Individual:

**Diagnoses:**

**Medications:**

**Primary Care Physician:** \_\_\_\_\_ Phone: \_\_\_\_\_

Other Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

**Referral Source**

Name \_\_\_\_\_ Agency/Relationship \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Where did you learn about our program? \_\_\_\_\_

Is Consumer Aware of Referral? \_\_\_Yes \_\_\_No Comments:

<b>Staff use only:</b>	Intake Staff Initials _____
<i>Date of First (1) Contact with consumer</i> _____	
<i>Referral Source Feedback date</i> _____	
<i>Given to Intake Coordinator</i> _____	

**Cognitive Functioning:** \_\_\_\_\_ alert and oriented \_\_\_\_\_ mild confusion  
\_\_\_\_\_ some memory impairment \_\_\_\_\_ Dementia Dx

**ADL's** (dressing, grooming, hygiene):

\_\_\_\_\_ independent \_\_\_\_\_ some assistance \_\_\_\_\_ dependent

Comments:

**Mobility:** \_\_\_\_\_ independent \_\_\_\_\_ assistive device \_\_\_\_\_; other: \_\_\_\_\_

**Transportation:** Drives Y N; Safety Concerns Y N; Other: \_\_\_\_\_

**Medications:** \_\_\_\_\_ manages w/o assist \_\_\_\_\_ compliance concern  
\_\_\_\_\_ manages with set up Comments:

**Formal Services and Community Resources** (N=Needs H=In Place)

\_\_\_\_\_ Food Stamps \_\_\_\_\_ Commodities \_\_\_\_\_ Cong. Meals  
\_\_\_\_\_ Home Del. Meals \_\_\_\_\_ Housekeeping \_\_\_\_\_ Vol. Visitor  
\_\_\_\_\_ Elderly Waiver (\_\_\_\_ in place, \_\_\_\_\_ applied for)

**Home Health Care:** Agency: \_\_\_\_\_  
\_\_\_\_\_ Nursing: RN \_\_\_\_\_; \_\_\_\_\_ Hmkr/HHA \_\_\_\_\_ PT/OT

**Contact Person(s):**

Name \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Relationship \_\_\_\_\_

**Income and Financial Resources:**

Source	Amount	Source	Amount
_____	_____	_____	_____
_____	_____	_____	_____

Are there financial Concerns: Y N

**Insurance** (Please include ID# if possible)

\_\_\_\_\_ Medicare \_\_\_\_\_  
\_\_\_\_\_ Supplement \_\_\_\_\_  
\_\_\_\_\_ Medicaid (Title XIX) \_\_\_\_\_

**Directions to Home/Condition of home/Barriers to access** (HOH, smoking, pets, etc.)