

# PAS EMERGENCY INTAKE

Non-Electronic Version



*Our Mission: Working together to provide services that help people maintain their independence.*

DATE: \_\_\_\_\_

CLIENT NAME: \_\_\_\_\_ STATE: \_\_\_\_\_ CNTY: \_\_\_\_\_

CAREGIVER CONTACT: \_\_\_\_\_ PHONE: \_\_\_\_\_

RELATIONSHIP TO THE PERSON: \_\_\_\_\_

MEDICAL CONTACT, IF NO CAREGIVER: \_\_\_\_\_ PHONE: \_\_\_\_\_

WHAT INCIDENT HAS OCCURRED THAT MAKES EMERGENCY NF PLACEMENT NECESSARY? \_\_\_\_\_

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

PRESENTING LOCATION: \_\_\_\_\_ HOME \_\_\_\_\_ EMERGENCY ROOM \_\_\_\_\_ A/L OR GROUP HOME

\_\_\_\_\_ OTHER (IDENTIFY LOCATION) \_\_\_\_\_

CURRENT LIVING ARRANGEMENTS? \_\_\_\_\_

HOW LONG CAN THE PERSON CONTINUE AT HOME? \_\_\_\_\_

CURRENTLY RECEIVING IN-HOME SERVICES? \_\_\_\_\_ YES \_\_\_\_\_ NO

IF YES, WHICH SERVICES? \_\_\_\_\_

COULD CLIENT REMAIN AT HOME WITH ADDITIONAL IN-HOME SERVICES? \_\_\_\_\_ YES \_\_\_\_\_ NO

*Note: Discuss all In-Home Options*

RECENT HOSPITAL STAY – DATE/EXPLAIN \_\_\_\_\_

LEVEL I: ALL \_\_\_\_\_ NO \_\_\_\_\_ YES: 1 2 3 4 5 6 7 LEVEL II REQUIRED? \_\_\_\_\_ YES \_\_\_\_\_ NO APS? \_\_\_\_\_ YES \_\_\_\_\_ NO

## MENTAL STATUS

- \_\_\_\_\_ ALERT
- \_\_\_\_\_ ORIENTED
- \_\_\_\_\_ CONFUSED/FORGETFUL
- \_\_\_\_\_ AGGRESSIVE/COMBATIVE/VIOLENT
- \_\_\_\_\_ COMATOSE

## MOBILITY

- \_\_\_\_\_ AMBULATORY \_\_\_\_\_ NON AMBULATORY
- \_\_\_\_\_ WITH ASS'T or ASS'T DEVICE
- \_\_\_\_\_ W/C
- \_\_\_\_\_ ASSISTED WITH TRANSFERS
- \_\_\_\_\_ FALLS \_\_\_\_\_ BEDFAST

## ADL'S - MIN. ASST MOD. ASST TOTAL

BATHING \_\_\_\_\_  
DRESSING \_\_\_\_\_  
MEDS \_\_\_\_\_

## ELIMINATION

\_\_\_\_\_ CONTINENT  
\_\_\_\_\_ INCONTINENT – BLADDER or BOWEL  
\_\_\_\_\_ CATHETER

**FOR PAS OFFICE USE:** BASED ON INFO PROVIDED, APPLICANT APPEARS TO HAVE A MEDICAL EMERGENCY THAT REQUIRES NF ADMISSION WITHIN 72 HRS OF REQUEST: \_\_\_\_\_ YES \_\_\_\_\_ NO