First Home Care

FHC Location			Program
Tidewater			Choose an item.
Admit/ Assess Date	**D/C Date**	**LOS**	**Reason for D/C**
Referral			

DEMOGRAPHICS

Name: Last	First	Middle	DOB
Gender	**Marital Status**	**Race**	**Social Security #**
Choose an item.	Choose an item.	Choose an item.	
Primary Phone #	**Type of phone**	**Secondary Phone #**	**Type of phone**
	Choose an item.		Choose an item.
Address: Street		**City**	**State** / **Zip**

LEGAL GUARDIAN

Does Individual have **Legal Guardian (LG)**? ☐ Yes *(fill LG info below)* ☐ No/Own LG *(skip to Emergency Contact)*

LG Name:	Relationship:
	Choose an item.

Is **LG contact info** different from client? ☐ Different *(fill LG contact info below)* ☐ Same as client *(skip to Emergency Contact)*

LG Primary Phone #	Type of phone	LG Secondary Phone #	Type of phone
	Choose an item.		Choose an item.
LG Address: Street		**City**	**State** / **Zip**

EMERGENCY CONTACT

Is **Emergency Contact** LG or another person? ☐ Another person *(fill info)* ☐ LG *(skip to "in case of emergency")*

Emergency Contact Name	Phone #	Relationship
Address	**In case of emergency, individual will be transported to**	
	Choose an item.	

BILLING INFORMATION

Medicaid #	Primary Insurance	Primary Insurance #	Copayments
			☐ n/a ☐ No ☐Yes: $
Crisis only: SA start/end dates	**Secondary Insurance**	**Secondary Insurance #**	**Copayments**
			☐ n/a ☐ No ☐Yes: $

Insurance Holder/Subscriber: ☐ Self *(if self, skip to next section)* ☐ Other *(if other, fill items below)*

Insurance Holder Name	Subscriber ID	DOB of Ins. Holder	Social Security #	Relationship to Individual

Special billing instructions:

REFERRAL SOURCE INFORMATION

Name of person making initial contact	Relationship	Contact Type	Date	Time
	Choose an item.	Choose an item.		
Referral Name, Title	**Agency Name**		**Department**	
Agency Address	**Agency Phone #**	**Email:**		

CLINICAL SITUATION

Click here to enter text.

SAFETY ASSESSMENT

Yes	None	Behavior	If yes, briefly describe including frequency, intensity & last episode if possible

	reported		
☐	☐	Suicidal Ideations	
☐	☐	Homicidal Ideations	
☐	☐	Psychosis	
☐	☐	Self-harm	
☐	☐	Physical Aggression	
☐	☐	Risk for Sexual Aggression	
☐	☐	Risk for Sexual Victimization	

MEDICAL STATUS

Yes	None reported	Condition	If yes, briefly describe including impact on individual
Referral Dx (Dx by, credentials, date)			Click here to enter text.
List of meds including dosage if known			Click here to enter text.
☐	☐	Medication compliant	
☐	☐	Active Medical Condition	
☐	☐	Food/Drug Allergies	
☐	☐	Physical limitations	
☐	☐	Cognitive limitations (i.e. TBI, LD, etc.)	
☐	☐	Special Education Status (IEP)	

LEGAL STATUS

Yes	None reported	Status	If yes, provide brief details
☐	☐	Criminal Charges/Convictions	
☐	☐	Parole/Probation	

END OF REFERRAL FORM

DIAGNOSIS

Admit Dx	**ICD-10 code:**	**Dx:**
Primary:		
Secondary:		
Dx by, credentials, date:		
D/C Dx	☐ Same as Admit ☐ Changed *(if changed, list codes below)*	
Dx by, credentials, date:		