DRTC

Intake/Emergency Information Form

Today's Date: _____ Application Date: _____

Name of person completing form: _____

Home Phone Number: (___) _____ Cell Phone Number: (___) _____

Please fill out <u>every</u> blank with information or "n/a"

Individual Information

Name: _____

Last First MI Preferred Name

Birth Date: _____ Gender: ☐ Male ☐ Female

Optional:

Ethnic origins: ☐ White ☐ Black or African American ☐ Asian ☐ Hispanic or Latino

☐ Two or more races ☐ Native Hawaiian or Pacific Islander

☐ American Indian or Alaskan Native Tribal Affiliation: _____

Religion: _____

Primary Language spoken in the household: ☐ English ☐ Spanish ☐ Vietnamese ☐ Sign Language

Other:

Marital Status: ☐ Single ☐ Divorced ☐ Widowed ☐ Married – Spouse's Name: _____

Address: _____ Home Phone # : (___) _____

_____ Cell Phone # : (___) _____

Email address: _____

Name of person/counselor who referred you: _____

Emergency Contact/Family/Guardian/Caregiver Information

Primary Contact Name: _____ Relationship: _____

Address: _____

Number City State Zip Code

Legal Guardian? ☐ Yes ☐ No

Phone: (___) _____ Mobile Phone: (___) _____

Email address: _____

Employer: _____ Employer Phone: (___) _____ ext. _____

<u>Additional Emergency Contact Information:</u>

Should we be unable to reach either the primary contact person or emergency contact person in case of emergency, please give name and phone number of two (2) **additional** people who will be able to help us reach you or who may be able to assist the individual in an EMERGENCY.

Name: _____ Home Phone: _____ Work Phone: _____

Relationship: _____ Mobile Phone: _____

Name:_____ Home Phone:_____ Work Phone:_____

Relationship:_____ Mobile Phone:_____

Medical Information

Primary Diagnoses:_____ Secondary Diagnoses:_____

Seizure Disorder? ☐ Yes ☐ No If yes, explain in detail what they look like:_____

_____

Has diabetes? ☐ Yes ☐ No

If yes, do you take: ☐ oral medication or ☐ injection

List any medication allergies:_____

List any other allergies:_____

Special diet/food restrictions? ☐ Yes ☐ No

Specifics/reason:_____

Glasses/contacts? ☐ Yes ☐ No

Do you use any special devices/equipment? (Check all that apply)

☐ Wheelchair ☐ Dentures ☐ Cane ☐ Walker ☐ Prosthesis ☐ Hearing Aid(s)

Other assistive device(s): _____

Last Psychological Exam:_____ Last Medical Exam:_____

Last Tetanus Shot (date):_____

Major Surgeries:_____

Height:_____ Weight:_____

Current Medications (attach additional sheet if needed):

Name	Dose/Frequency	Side Effects	Purpose	Add'l Instructions

Physician Name:_____ Phone Number:_____

Preferred Hospital:_____

Dentist Name: _____ Phone Number:_____

Medicaid/SoonerCare? ☐ Yes ☐ No Medicaid/SoonerCare #:_____

Medicare? ☐ Yes ☐ No Medicare #:_____

Primary Insurance (if applicable):_____

Insurance Number:_____

Secondary Insurance (if applicable):_____

Insurance Number:_____

NOTE: Individuals taken to the hospital by ambulance are taken to the hospital deemed most appropriate by the Ambulance Emergency Medical Staff. Dale Rogers Training Center is not responsible for reimbursements for medical attention or any other type of compensation for emergency treatment **(except for Worker's Compensation cases**).

Additional Information

SSI Recipient? ☐ Yes ☐ No SSDI Recipient? ☐ Yes ☐ No

Mobility/Physical Limitation(s):_____

Work Limitations:_____

LIST ANY OTHER MEDICAL CONDITIONS THAT MAY BE IMPORTANT IN CASE OF MEDICAL TREATMENT:

_____

_____

Procedure

The individual and/or guardian/family/caregiver is responsible for completing and updating information on the Intake/Emergency Information Form through their assigned case manager/program designee, who ensures that all questions are answered or “n/a” is indicated. The information is then entered into the Database System by the Case Manager/Program Designee within 24-hours of receipt of the information and printed onto one sheet (front and back) and copied according to Emergency Contact Information policy.