DEBRA LEVY
Eldercare Associates

Pre-assessment Worksheet

Name: _____ **Date:**_____

Age: _____ **DOB:** _____

Address: _____

Phone Number(s): (c) _____ (h) _____ (w)_____

Family/Emergency Contact Information: ****** denotes legal guardian/ power of attorney

Name	Address	Phone number	Relationship

Primary Insurance Information:

Policy name and type:_____

Policy number: _____

Secondary Insurance Information:

Policy name and type:_____

Policy number: _____

Allergies (list allergen and reaction):

Allergen	Reaction

Known Diagnoses:_____

Pharmacy Name:_____ **Number:**_____

DEBRA LEVY
Eldercare Associates

Pre-assessment Worksheet

Medications:

Name	Medication	Frequency (daily, twice a day, etc.)

Practitioners:(primary care, specialist, dentist, optometrist,…etc)**:**

Name	Specialty	Phone number

Billing info:

Bill to: _____

Address: _____

_____

Phone: _____ Email: _____

Completed by: _____ **Relationship to client:** _____