VERA LLOYD PRESBYTERIAN HOME AND FAMILY SERVICES, INC.
RESPITE CARE INTAKE

Youth Name: ____________________ SSN: ______________________________

Admission Date: __________________ Discharge Date: _____________________

Date of Birth: ____________________ Medicaid #/Insurance: _________________

Home Street Address: __________________________________ County: ____________

City, State, Zip: ____

Race: _____ Sex: _____ Height: _____ Wgt: _____ Hair Color: _____ Eye: ______

Legal Status/Custody: __________________________________ Religion: __________

Referral Source: ____

Placing Worker's Name: ____

Primary Worker's Name: ____

Address: ____

City, State, Zip: ____

Phone Number: _____________________ Fax Number: ________________________

Placement Reason: ____
____
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(Revised 3/2008)

VERA LLOYD PRESBYTERIAN HOME AND FAMILY SERVICES, INC.
RESPITE CARE INTAKE

Youth Name: ______________________ DOB: ________ Date: ______________

Placement History: ____
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Brief Social History: ____
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Behavioral Problems: ____
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Special Needs: ____
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____

VERA LLOYD PRESBYTERIAN HOME AND FAMILY SERVICES, INC.
RESPITE CARE INTAKE

Youth Name: ____________________ DOB: _______ Date: _____________

Other Pertinent Information: ____
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Summary of Discharge Plan: ____
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____

Guardian's Signature: ____________________ Date: __________

Placing Agent's Signature: ________________ Date: __________

Youth' Signature: _______________________ Date: __________

VLPH Staff Signature: ___________________ Date: __________

VERA LLOYD PRESBYTERIAN HOME & FAMILY SERVICES, INC.
RESPITE CARE INTAKE

HEALTH AND MEDICAL HISTORY

Youth Name: ____________________ DOB: _______ Date: _____________

Completed by: ____________________ Source (s) of Information: ______________

Insurance Company/Medicaid Number: ____

	Date of Exam/Appt.	Name/Address of Dr./Dentist
Physical Examination	________________	________________________
Eye Examination	________________	________________________
Hearing Examination	________________	________________________
Dental Examination	________________	________________________
Psychiatric Appointment	________________	________________________
Therapist or Counselor	________________	________________________

Please circle the following and give the approximate date/age you had any of the following:

Childhood Diseases:

Mumps	yes	no	Age: ___________________
Measles	yes	no	Age: ___________________
Chicken Pox	yes	no	Age: ___________________
Rheumatic Fever	yes	no	Age: ___________________
Polio	yes	no	Age: ___________________
Sickle Cell Anemia	yes	no	Age: ___________________

Other: ____

Medications: ____
____
____

Allergies (food, medications or any other substance): _____________________________
____
____

Hospitalizations or Surgery (include type and date): ______________________________
____
____

Substance abuse history: ____
____
____

VERA LLOYD PRESBYTERIAN HOME & FAMILY SERVICES, INC.
RESPITE CARE INTAKE

HEALTH AND MEDICAL HISTORY

Youth Name: ____________________ DOB: _______ Date: _____________

Family History (who):

Diabetes	________________________________
Tuberculosis	________________________________
Cancers	________________________________
High Blood Pressure	________________________________
Kidney Disease	________________________________
Heart Disease	________________________________
Allergies	________________________________
Mental Problems	________________________________
Anemia	________________________________

Current Physical Symptoms (please check the appropriate box)

	Yes	No		Yes	No
Fainting	___	___	Seizures	___	___
Nausea	___	___	Nervousness	___	___
Diarrhea	___	___	Joint Pain	___	___
Constipation	___	___	Nightmares	___	___
Urinary Infections	___	___	Difficulty Sleeping	___	___
Headaches	___	___	Difficulty Relaxing	___	___
Stomach Aches	___	___	Temper	___	___
Skin Problems	___	___	Other: __________	___	___

Comments: ____
____

Guardian's Signature: ______________________ Date: __________

Placing Agent's Signature: ________________ Date: __________

Youth' Signature: ________________________ Date: __________

VLPH Staff Signature: ____________________ Date: __________