St. John's Respite Program Intake Form

Caregiver Information: **Date:**

Name:

Address:

County:

Phone:

Email:

DOB:

Relationship to Participant:

Program Participant Information:

Name:

Address (if different from caregiver):

Phone (if different from caregiver):

Lives: Alone ☐ or ☐ With: Family/Friend/Significant Other or Other:

Emergency Contacts:

First Emergency Contact:

Name: Relationship to Participant:

Phone Number: Home/Cell/Work:

Second Emergency Contact:

Name: Relationship to Participant:

Phone Number: Home/Cell/Work:

Screening - Diagnosis and Criteria: ***(Please answer the following questions as "Yes" or "No.")***

Is the program participant independent with the following:

Walking:

Getting up from a seated position:

Toileting:

Eating:

General Information:

Medical Diagnosis:

Is he/she at risk for falling?

Does he/she use a walker/cane?

Does he/she use a wheelchair?

Does he/she have any sensory impairments?

Hearing:

Vision:

Other:

Is the program participant prone to wandering?

Physical Aggression?

Verbal Aggression?

Any Allergies? (Food, Medication, etc.):

Other medical concerns that staff/volunteers should be aware of: