Imperial Companions
Office: (678) 235-4315

Section 1 - Intake

Caregiver's Name: _____

Participants Name:_____

Address: _____

City:_____ State:___ Zip Code:_____

Day Time Phone Number: ( ) _____

Cell Phone Number: ( ) _____

E-mail Address: _____

Caregiver's Age: ___ DOB:_____ Participants Age: ___ DOB:_____

Please Indicate Family Income:

____$0-$10,000___&10-15,000___$15-25,000___$25-$35,000___$35-45,000 __over $45,000

Household Size:

Sex of Caregiver: M F Sex of Participant: M F

Race

Caregiver	Participant
____	____ White (Non-Hispanic)
____	____ African American
____	____ Latino
____	____ Asian
____	____ Native American
____	____ Other: _____

Please Indicate Disability

__ ID/DD Diagnosis: _____

__Physical Disability

__Victim or Survivor of Abuse/neglect

__Multiple Disabilities Describe: _____

__Emotional/Behavior Challenges Describe: _____

__Chronic Illness

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__IEP Plan_____

__PTSD

Participant Lives: (*please check one*) __Caregiver only __Caregiver and other family members

Other: _____

List other members of the home:

Name Age & DOB Special Needs

_____

_____

_____

Other Services Currently Receiving: *(Please Indicate if on a waiting list)*

__COP/CIP __Family Support __ICWP __NOW ___CCSP __Source __COMP ___GAPP

__VA Benefits __VR ___Care Coordination __ GA Planning for Healthy Babies ___GA Pediatric Program

__GA Community Based Alternatives for Youth __SSI __Medical Assistance __Housing __Daycare Assistance

**How Long on waiting list (if applicable):* _____

Other Services not listed: _____

Name of Case Manager/Support Coordinator: _____

If you need information on programs available to you please indicate: Yes No *(Please circle one)*

Which programs are of Interest?

_____

_____

_____

Briefly describe why you are in need of respite care/community support/summer/semi-independent support

_____

_____

_____

How did you hear about Imperial Companions? _____

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Section II - Emergency Sheet

PARTICIPANT'S NAME: _____

Emergency Contact other than primary caregiver

Name: _____ Relationship: _____

Address:_____ City:_____ Zip: _____

Home Phone: ( )_____ Work: ( ) _____ Cell: ( )_____

Emergency Contact other than primary caregiver

Name: _____ Relationship: _____

Address:_____ City:_____ Zip: _____

Home Phone: ( )_____ Work: ( ) _____ Cell: ( )_____

Type of Communication: __Vocal ___ Sign Language __Other:_____

Legal Guardian:

Name:_____ Relationship:_____

Address:_____

Primary Physician:

Name: _____ Phone: ( ) _____

Brief Medical History:_____

Special Medical History/Problem:_____

ALLERGIES:

1. _____ Reaction: _____

2. _____ Reaction: _____

3. _____ Reaction: _____

MEDICATIONS: *(If more than 4 medications, please list on reverse)*

Name of Medication	Dosage	Time(s)	Route	Purpose

1. _____

2. _____

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3. _____

4. _____

Dietary Needs: _____ Date of Last Tetanus: _____

CONSENT FOR MEDICAL/HOSPITAL CARE

Imperial Companions staff has the authorization to obtain appropriate medical care for the above named individual in the event of an emergency and has permission to obtain all appropriate medical information regarding his/her medical care at medical/clinic visits and hospitalizations: ____Yes ____No

Hospital Preference: (circle one)

Dekalb Medical Grady Emory Shepherd Center Piedmont Other_____

Insurance Co:_____ ID#_____

MediCare ___No ___Yes ID#_____ Medicaid ___No ____Yes ID#_____

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Imperial Companions is authorized to administer any prescribed/PRN medication by medication certified staff __Yes __No

This authorization is valid unless revoked in writing or when there are any changes in guardianship status for the above named individual.

Signed _____ Date _____
(If person is adjudicated, signature of legal guardian)

_____ Date_____
Imperial Companions Staff Signature/Title