LONG-TERM CARE PREQUALIFICATION WORKSHEET

Client Age: _____

Gender:

Male ○

Female ○

Height: _____

Weight: _____

Tobacco Usage:

Never ○

Current ○ Type: _____

Former ○ Type: _____

Date Stopped: _____

Are you currently using, or in the past 12 months have you used or been medically advised by a Healthcare Professional to use any of the following? Check all that apply.

- ☐ Care in a nursing facility
- ☐ Home Health care services
- ☐ Adult Day Care services
- ☐ Walker
- ☐ Wheelchair
- ☐ Multi-prong cane
- ☐ Motorized Scooter
- ☐ Hospital bed
- ☐ Stair Lift
- ☐ Oxygen
- ☐ Dialysis machine
- ☐ Hospice Care

Do you require assistance or supervision in performing any of the following activities? Check all that apply.

- ☐ Taking medication
- ☐ Bathing
- ☐ Dressing
- ☐ Getting in or out of a chair or bed
- ☐ Eating
- ☐ Toileting
- ☐ Managing your bowel or bladder
- ☐ Walking

In the last 7 years, have you had, been diagnosed or treated by a Health Care Professional, been prescribed or taken medication for any of the following? Check all that apply.

- ☐ Active-duty military personnel
- ☐ Alcoholism-active
- ☐ Alzheimer's disease or dementia
- ☐ Autoimmune disorder/disease such as Lupus, Scleroderma, CREST Syndrome, Connective Tissue disease
- ☐ Balance disorder/gait impairment
- ☐ Cerebral palsy
- ☐ Cirrhosis
- ☐ Down syndrome
- ☐ Drug addiction/illicit drug usage-within 10 years
- ☐ Hepatitis
- ☐ Huntington's disease
- ☐ Intellectual disability
- ☐ Internal cancers (Stage 4 or not cured or in remission)
- ☐ Lou Gehrig's Disease (ALS)
- ☐ Macular degeneration/progressive/"wet"
- ☐ Memory loss
- ☐ Mental incapacity or retardation
- ☐ Mild cognitive impairment (MCI)
- ☐ Multiple myeloma
- ☐ Multiple sclerosis
- ☐ Muscular dystrophy
- ☐ Non-ocular myasthenia gravis
- ☐ Organ transplant other than cornea or kidney
- ☐ Organic brain syndrome
- ☐ Osteoporosis with compression fracture(s)
- ☐ Paralysis
- ☐ Parkinson's disease
- ☐ Pending Surgery
- ☐ Receiving SSDI
- ☐ Recurrent memory loss
- ☐ Smoking in conjunction with Emphysema, COPD
- ☐ Spinal Stenosis or Chronic Back pain with use of narcotic medication
- ☐ Stroke or Multiple Transient Ischemic Attack (TIA)
- ☐ Ventricular tachycardia

Please provide the following additional information regarding any "Yes" answers:

Condition	Date of Diagnosis	Date Treatment Completed

Please list your current medications:

Name of Medication	Dosage	Reason

Physician Information

Physician Name: _____ Phone: _____

Address: _____ Date last seen: _____

_____

Reason Seen:

Physician Name: _____ Phone: _____

Address: _____ Date last seen: _____

_____

Reason Seen:

Physician Name: _____ Phone: _____

Address: _____ Date last seen: _____

_____

Reason Seen:

Notes & Additional Information