



Starfish Resources

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Date: _____

*Fax or email
completed form to
Starfish Resources*

INFORMATION REQUEST FORM

Your Name: _____

I am contacting Starfish Resources for: self family friend other _____

Best way to reach you? Phone: (____) _____ Mail: (Provide Address Below)
 e-mail: _____

How can we help you? _____

The information below will help us help you faster:

Coverage: Medi-Care Medi-Cal Veteran Long Term Care Ins. Other: _____

Primary / Secondary Diagnosis: _____ History: _____

Last Hospitalization Date: _____ Reason: _____

Hospitalization Frequency in Last 18 Months? _____

Cognition: (Check all that apply)

Alert Independent Mild Cognitive Impairment Alzheimer's Dementia
 Psych Meds Depression Anxiety Other Behaviors: _____

Physical Condition: (Check all that apply)

Ambulatory Non-Ambulatory Bed-Bound Wounds: _____
Assisted Device(s): Cane Walker Wheel Chair Other: _____

Notes: _____

Care Needs: (Check all that apply)

Meals Toileting Glasses Oxygen Hospice
 Bathing Incontinent U/B Dentures IV Catheter Care
 Dressing Medications Hearing Aids Diabetic NI/ID Ostomy Care
 Other: _____

Other Needs: (Check all that apply)

Estate Planning/Trusts Geriatric Care Management Long Term Care Insurance
 Relocations/Downsizing Medi-Care Ins. Information Emergency Response System
 Funeral Pre-Planning Home Care, Non-Medical Reverse Mortgage

Responsible Party/POA/Next of Kin: _____ Phone: _____

City: _____ State: _____ E-Mail: _____