Mileage Average:

[] Spanish Speaker

BLINDNESS SUPPORT SERVICES INC.
THE ROAD TO INDEPENDENCE

[] Phone Contact

[] Presentation
[] Health Fair
[] Other

Department of Older Adults Intake Form

Date: _____

Name: _____ Gender: Male/Female/Didn't Self Identify

Race: [] _____ [] Didn't Self Identify Hispanic/Latino Ethnicity: [] Yes [] No

Phone Number: _____ DOB: _____ Age: _____

Address: _____ City/Zip: _____

Please Mark One of the Fallowing in Each Category

Degree of Visual Impairment:

[] Total (LP or NLP) [] Legally Blind [] Severe Visual Impairment

Major Cause:

[] Macular Degeneration [] Diabetic Retinopathy [] Glaucoma

[] Cataracts [] Other: _____

Other Age-Related Impairments:

[] Hearing [] Mental Health/Mood Disorders

[] Communication (Expressive/Receptive Communication)

[] Mobility Impairment (Bone, Muscle, Joint, Parkinson's, etc.)

[] Cognitive/Intellectual (Alzheimer's, Down Syndrome, etc.)

[] Other Impairments: _____

Living arrangement:

[] Alone [] With Others

Emergency Contact Information

Name: _____

Relation: _____

Phone Number: _____

Notes:

_____

_____

_____

_____

_____

Pets: Yes [] No []

Type: _____

Type of Residence

[] Private (House/Apartment) [] Senior Independent Living Facility [] Assisted Living Facility

[] Nursing Home/Long Term Care Facility [] Homeless

Source of Referral