



Client Screening Form 645.B.1

Date of Contact with Individual: _____

Individual name _____

Sex: M _____ F _____ DOB: _____

Street _____ City _____ State _____ ZipCode _____ County _____

Home phone: _____ . Work phone: _____ . Cell phone: _____

Individual present residence (check one)

Home _____ Hospital _____ Residential Treatment Center _____ Group Home _____

Foster Home _____ Other (specify) _____

Reason for requesting services (includes medical DSM-IV Diagnosis)

Individual Disposition including referral to other services for further assessment, placement on a waiting list for service or admission to the services: _____

PAN Homehealth Support Services Representative:

Date: