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| **DEPARTMENT OF HEALTH SERVICES**Division of Quality AssuranceF-02400 (01/2019) | **STATE OF WISCONSIN** |

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| **CLIENT TRANSFER: ASSISTED LIVING FACILITY CLIENT FACE SHEET** |
| * See DQA publication [P-02067, *Assisted Living Facility and Hospital Interface*](https://www.dhs.wisconsin.gov/publications/p02067.pdf)*.*
* A copy of the client’s face sheet would be included in the blue envelope packet.
 |
| **GENERAL** |
| Name – Client | Phone |
| Address | City | County | State | Zip Code |
| DOA: |  | DOB / Age: |  |  | Height: |  |
| Medicaid No: |  | SSN: |  | Weight: |  |
| Medicare No: |  | Sex: |  | Hair Color: |  |
| Effective Date: |  | Race: |  | Eye Color: |  |
| Medicare Part D Provider: |  | No. |  |
| **DIAGNOSIS** |
|  | Axis I: |  |
| Axis II: |  |
| Axis III: |  |
| Allergies: |  |
| Behavior plan needed? [ ]  Y [ ]  N | Consent for psych meds needed? [ ]  Y [ ]  N | Health log updated? [ ]  Y [ ]  N |
| **GUARDIAN / CASE MANAGERS** |
| Name – Guardian | Phone – Guardian |
| Name – Family Care Case Manager | Phone – Family Care Case Manager |
| Name – Managed Care Organization (MCO) | Phone – MCO |
| **CONTACT INFORMATION** |
| **Contacts** | **Name** | **Address** | **Phone** |
| Emergency Contact |  |  |  |
| Primary Care Physician |  |  |  |
| Hospital |  |  |  |
| Pharmacist |  |  |  |
| Dentist |  |  |  |
| Eye |  |  |  |
| Psychiatrist  |  |  |  |
| Podiatrist |  |  |  |
| Vocational Provider |  |  |  |
| Transportation Provider Transportation |  |  |  |