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| **DEPARTMENT OF HEALTH SERVICES**  Division of Quality Assurance  F-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 | |  | | | | |  | | | | | | | | | | |  | | |