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

CLIENT TRANSFER: ASSISTED LIVING FACILITY CLIENT FACE SHEET

- See DQA publication P-02067, *Assisted Living Facility and Hospital Interface*.
- 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			