

Subscriber # \_\_\_\_\_

**CLIENT INTAKE FORM for all services  
aka Careplan**

Intake Date:

Interviewer:

<input type="checkbox"/> New Client	<b>Type of Equipment</b>	<input type="checkbox"/> HomeSafe landline	<input type="checkbox"/> GoSafe landline
<input type="checkbox"/> Current client		<input type="checkbox"/> HomeSafe wireless	<input type="checkbox"/> GoSafe wireless
<input type="checkbox"/> Multimember service			

**CLIENT INFORMATION**

Where did you hear about Lifeline? \_\_\_\_\_

Language other than English: \_\_\_\_\_

**Client does not have Implantable devices such as:**

**Pacemaker, defibrillator, insulin pump, etc are NOT allowed to be used with GoSafe**

Mr Ms Mrs	Client First & Preferred Name	Client Last Name
Home #:	Cell #:	Email:
Address:		Entry code: _____
		Buzzer code: _____
<input type="checkbox"/> House	<input type="checkbox"/> Suite	<input type="checkbox"/> Apartment
<input type="checkbox"/> Trailer	<input type="checkbox"/> Townhouse	<input type="checkbox"/> Condo
<input type="checkbox"/> Patio Home	<input type="checkbox"/> Mobile Home	
Complex Name:		
Direction to home:		
Type of Pet	Emergency contact:	

**SITE OPTIONAL INFORMATION**

Hidden Key location:			
Entry Code/Buzzer:		Lockbox location:	
Lockbox Code:	<input type="checkbox"/> Lifeline Provided <input type="checkbox"/> Client Owned	Lockbox tracking code:	Location of Lifeline Unit:

**MEDICAL INFORMATION**

Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Are there any Firearms in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, where & what type?	
Special Needs	<input type="checkbox"/> Walker <input type="checkbox"/> Cane <input type="checkbox"/> Wheelchair <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Glasses <input type="checkbox"/> Home Support		
Smoker or does anybody in the household smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Medications</b>	<b>Drug Allergies</b>	
<b>Medical Condition:</b>	<input type="checkbox"/> ASA <input type="checkbox"/> Anticoagulants (eg. Coumadin) <input type="checkbox"/> Dialysis <input type="checkbox"/> Heart Medication (eg. Digoxin, Nitro) <input type="checkbox"/> Insulin <input type="checkbox"/> Blood Pressure Meds <input type="checkbox"/> Oxygen	<input type="checkbox"/> Adhesive Tape <input type="checkbox"/> Amoxicillin <input type="checkbox"/> Ampicillin <input type="checkbox"/> Aspirin <input type="checkbox"/> Codeine <input type="checkbox"/> Erythromycin <input type="checkbox"/> Morphine <input type="checkbox"/> Naproxen <input type="checkbox"/> Penicillin <input type="checkbox"/> Sulfa Drugs <input type="checkbox"/> Tetracycline	
<b>Medical History:</b> (ex: stroke Nov 2016) Only info important to EMS	<b>Medication Location:</b>		
Personal Health Number:			
Doctor Name:		Phone:	

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**RESPONDER INFORMATION**

Discuss with client, all phone conversations between Philips and you or your responders may be recorded

**Responder #1 Relation:**

First Name	Last Name		
Home:	Cell:	Other:	
Address:			
Email:	<input type="checkbox"/> Has key or access to residence	_____ Minutes away	
<input type="checkbox"/> RES	<input type="checkbox"/> RESNOK	<input type="checkbox"/> NOK	<input type="checkbox"/> Mobile RES

**Responder #2 Relation:**

First Name	Last Name		
Home:	Cell:	Other:	
Address:			
Email:	<input type="checkbox"/> Has key or access to residence	_____ Minutes away	
<input type="checkbox"/> RES	<input type="checkbox"/> RESNOK	<input type="checkbox"/> NOK	<input type="checkbox"/> Mobile RES

**Responder #3 Relation:**

First Name	Last Name		
Home:	Cell:	Other:	
Address:			
Email:	<input type="checkbox"/> Has key or access to residence	_____ Minutes away	
<input type="checkbox"/> RES	<input type="checkbox"/> RESNOK	<input type="checkbox"/> NOK	<input type="checkbox"/> Mobile RES

**Responder #4 Relation:**

First Name	Last Name		
Home:	Cell:	Other:	
Address:			
Email:	<input type="checkbox"/> Has key or access to residence	_____ Minutes away	
<input type="checkbox"/> RES	<input type="checkbox"/> RESNOK	<input type="checkbox"/> NOK	<input type="checkbox"/> Mobile RES

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**EQUIPMENT**

**System/Unit Model:**

- Regular Unit(6904/AT)       7000C (wireless)       7000L (landline)       Extender

Base Unit # \_\_\_\_\_ Base Unit: S/N \_\_\_\_\_ Battery expiry date: \_\_\_\_\_

**Personal Help Button info:**

**Traditional button -**     Neckcord       Wristband       AutoAlert

**7000 button -**     7000PHB (neck)     7000PHW (wrist)     Wireless 7000AHB (AA)     GoSafe (MOB)

**Record chosen Code/Serial Number:** \_\_\_\_\_ **Expiry date:** \_\_\_\_\_

**Additional Service**

**Access Package:**     Pillow Switch       Rocking Lever       Wobble Switch

**FINANCIAL INFORMATION & SERVICE REQUEST**

**Activation Fee:    \$40.00**

**Monthly Monitoring Fees**

- Traditional Button      35.00
- AutoAlert      55.00

**Wireless options**

- Wireless traditional PHB    45.00
- Wireless AutoAlert      65.00

**GoSafe commitment**

**- minimum 6 months contract**

- 7000L/mo      75.00
- 7000C/mo      85.00

**Accessories**

- Lockbox      2.00
- Extender      10.00

**Extra buttons:**

- Traditional button      5.00
- AutoAlert      15.00
- GoSafe      40.00

**Misc**

- coupon
- EFT
- SGF Application
- Other arrangements made (record in Financial notes)

**Veterans Affairs Canada VAC/DVA**

File # K \_\_\_\_\_

**ICBC / WCB**

Claim # \_\_\_\_\_

**Financial Notes:**

**Service Request/Arrangement**

The Subscriber agrees that (a) the information on this Care Plan is accurate and complete as of the date indicated below; (b) this Care Plan forms and integral part of, and is subject to the terms of, the subscriber monitoring Agreement entered into between Subscriber and Alberni Lifeline:

Subscribers Signature: \_\_\_\_\_

Date: \_\_\_\_\_