Mercy Family Health Center- Medical Safe Haven
Patient Intake Form

Client: _____ DOB: _____

Client Contact #: _____ Insurance: _____

Agency: _____ Date of referral: _____

Case Worker Name: _____ Contact #: _____

Date of Establishment: _____ via ( ) Court Order ( ) Voluntary Enrollment ( ) Other

Social History

- Primary Language: _____
- In the Foster System? (YES) (NO)
- City of Birth: _____
- Initial Age when exploited: _____

How many visits to the Emergency Department in the last 12 months? _____

- What hospital? _____

Goal for appointment (check all that apply):

___ Establish Care ___ Pregnancy

___ Mental health ___ Injury

___ STI screening ___ Substance/Alcohol use

___ Medications Other: _____

List current medications:

_____

_____

Client's primary mode of transportation to appointments?

___ Agency provided ___ Self ___ Does not have transportation

Does client have children who need care as well? (YES) (NO)

Does the patient know our clinic's particular involvement with your agency? (YES) (NO)
Will the caseworker be coming to the intake appointment with the client? (YES) (NO)

Please fax back to 916-688-1012:

ATTN: Medical Safe Haven 11/06/2018 v2