ElderBridge SoCal

ASSESSMENT OF SERVICE NEEDS
How would you like ElderBridge SoCal to help?

We want to understand your needs to determine if we are the best fit for you. You may simply call 909.720.8172 and talk to us. OR if you would like to prepare before calling, go through this Assessment and check what you are considering asking us to help with. Cross out and change wording as appropriate. Add anything else as it applies to your unique situation. THEN CALL. Please note the term "client" here refers to the person we would serve directly. The term "agent" refers to the person completing this assessment with another person in mind. The term "partner" refers to an ElderBridge SoCal staff member.

YOU ARE ____ the Client or ___ the Agent for someone else

STATUS: ____ Client is in hospital ____ Client is at home ____ Client is at _____

CLIENT LIVES: ____ independently ____ in assisted living ____ in a skilled nursing facility

CLIENT IS: ____ steady walking alone ____ would like an arm to hold ____ uses cane
____ uses walker ____ uses wheelchair

CLIENT HAS: ____ memory impairment ____ speech/language difficulties ____ hearing impairment
____ vision impairment/blind ____ other problems:

YOU ARE INTERESTED IN HAVING ELDERBRIDGE SOCAL:

____ Spend time coaching independent living, optimal safety and whole-person health

____ Manage transportation to and from requested healthcare appointment(s)

____ Attend healthcare appointment(s): to ensure client talks about important symptoms, problems and questions; to hear and clarify answers, diagnoses and options for treatment; to understand in order to report to family/primary caregiver or client (patient advocacy)

____ Coach client or caregivers to successfully implement treatment plans

____ Evaluate effectiveness of care plan and advocate as needed for changes

____ Record current medications and supplements and provide printed document

____ Assist in filling pill organizer (circle one): Weekly Twice a month Monthly

____ Spend time at bedside or at side of client to understand the situation, advocate for best care and be communication liaison between client, family/primary caregiver and healthcare practitioners

____ Assist with transition to next level of care, according to decisions of client and/or agent designated as primary caregiver or Power of Attorney

____ Communicate as appropriate with health care team and/or designated support person(s)

____ OTHER NEEDS/REQUESTS:

YOUR NAME: _____ EMAIL: _____

PHONE: _____

NOW GIVE A CALL TO 909.720.8172 or EMAIL this form to ElderBridgeSharon@gmail.com. She will be happy to answer any questions and guide you through the ENROLLMENT and AGREEMENT steps.