Medication Screening Intake

Today's Date: ________________

Please print clearly and fill-out this intake, completely. Thank you!

Name: ______________________________ DOB: __________ ☐ M ☐ F

Home Address: ______________________ City/St: __________ Zip: ______

Mailing Address: ______________________ City/St: __________ Zip: ______

Phone Number: ____________________ Alternate Number: ______________

County: ______________________ Email: ________________________

At or below poverty level?

☐ **Yes** ☐ **No**

Persons in Family Unit	Poverty
1	$15,960 or below
2	$21,640 or below

Race:

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White Non-Hispanic
- ☐ White Hispanic

Ethnicity:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Not Reported

I authorize the pharmacist to speak to the following person/s (i.e. spouse, children, caregiver) in regards to my health conditions, medications and interactions: (optional)

☐ Name/Relationship: ____

☐ Name/Relationship: ____

Consumer Information Release

By signing this authorization, you are providing the Area Agency on Aging of the Capital Area (AAACAP) permission to release your information, which includes protected health information, to the Pharmacist. This will allow staff to assist in assessing, arranging and meeting your service needs, in particular to a medication screening. Failure to provide this authorization will result in limited service by the AAACAP. This release includes access to a continuum of service/s available through the AAACAP and/or its providers.

______________________________ ______________________

Consumer's Signature Date

Notice to Consumer:

- Once the authorization to release your information is granted, AAACAP is not responsible for any redisclosure of the information by the recipient.
- You can withdraw permission you have given the AAACAP to use, or disclose health information that identifies you; unless, the AAACAP has already taken action based on your permission. You must withdraw your permission in writing.

Consumer's Full Name:	DOB:

The following information is required for the Pharmacist to provide you with a complete customized medication screening.

Emergency Contact:_________________________ Phone: ______________________________

Primary Care Physician:______________________ Phone: ______________________________

Smoke: ☐ No ☐ Yes; how much:____________

# of falls in the last 30 days: ____________

Date of last flu vaccine: ______________________

Alcohol: ☐ No ☐ Yes; how much:_______

Year of last pneumococcal vaccine: ____________

Caffeine: ☐ No ☐ Yes; how much: ______

Drug Allergies: _____________________________
____

Visual Impairment: ☐ No ☐ Yes:____

Hearing Impairment: ☐ No ☐ Yes:____

Dental Problems: ☐ No ☐ Yes:____

Health Conditions: *(please list all known)* ____
____
____
____

Please list any specific questions, concerns, comments or additional information you have for the pharmacist:

____
____
____
____
____
____
____

Consumer’s Full Name:	DOB:

Medication & Dosage (prescriptions, over-the-counter, herbals & vitamins)	Qty	Date Last Filled	Directions (as listed on pharmacy label)
Example: atorvastatin 20mg	30 days	1/3/2019	Take 1 tablet by mouth once daily

Your participation is greatly appreciated!

Area Agency on Aging of the Capital Area
Consumer Rights & Responsibilities for Older Americans Act Programs

The Area Agency on Aging of the Capital Area welcomes you as a participant in programs for older individuals and family caregivers in our region. This program is mandated by the Older Americans Act of 1965, as amended, and provides access and assistance and other supportive services. The programs and services are administered by the Area Agency on Aging with funding provided through the Texas Department of Aging and Disability Services, consumer contributions and local funding.

Programs and services are designed for individuals age 60 or older and/or their family members and other caregivers. Our goal is to assist older individuals in leading independent, meaningful and dignified lives in their own homes and communities as long as possible through the provision of limited support services. Information will not be released to anyone, or any agency without your informed consent, with the exception of records subpoenaed by a court of law.

Consumer rights and responsibilities:

1. You have the right to be treated with respect and consideration. You have the right to have your property treated with respect.
2. You may not be denied services on the basis of race, religion, color, national origin, sex, disability, marital status, or inability and/or unwillingness to contribute.
3. You have the right to make a complaint/grievance or recommend changes to policy or service, without restraint, interference, coercion, discrimination or reprisal. To make a complaint or grievance contact the Area Agency on Aging. Contact information is identified below:

Jennifer Scott
Director of Aging Services
Area Agency on Aging of the Capital Area
6800 Burleson Rd., Bldg. 310, Ste. 165
Austin, Texas 78744

4. You have the right to participate in the development of a care plan to address unmet needs.
5. You have the right to be informed in writing of available services and the applicable charges if the services are not covered or are unavailable by Medicare, Medicaid, health insurance, or Older Americans Act funding.
6. You have the right to make an independent choice of service providers from the list furnished by the Area Agency on Aging where multiple service providers are available and change service providers when desired.
7. You have the right to be informed of any change in service(s).
8. You have the right to make a voluntary, confidential, contribution for services received through the Area Agency on Aging. Services will not be denied if an eligible participant is unable or chooses not to make a contribution. All contributions will be kept confidential and will be utilized to expand or enhance the service(s) for which they were provided.
9. You have the responsibility to inform the Area Agency on Aging or its service provider(s) of your intent to withdraw from the program or any known periods of absenteeism when services will not be utilized.
10. You have the responsibility to provide the Area Agency on Aging or its services provider(s) with complete and accurate information.

I hold harmless this Area Agency on Aging program, its parent organization, funders, and the sponsoring state agencies for any liability arising out of the services provided in accordance with program guidelines.

______________________________________ ______________________
Consumer Signature Date