Client Intake Form

Alice Esso Concierge Nursing, LLC | Independent RN Care Navigation

Purpose of This Form
This form helps gather information to better understand your needs and provide personalized concierge nursing support. Services are educational, supportive, and do not include direct clinical care or treatment.

1. Client Information

Full Name: _____ Date of Birth: _____

Phone Number: _____ Email: _____ Preferred Language: _____

Address: _____

Preferred Contact Method: ☐ Phone ☐ Email ☐ Text ☐ Other (Please specify)
_____

Primary Care Physician (PCP): _____ PCP Phone: _____

Preferred Pharmacy: _____ Allergies: _____

2. Recent Care Setting

☐ Hospital Discharge
☐ Emergency Department Visit
☐ Skilled Nursing Facility
☐ Rehabilitation Facility
☐ Home / Self Referral (No recent admission)

Discharge Date (if applicable): _____

3. Reason for Referral / Primary Needs

☐ Post-hospital transition support
☐ Non-emergency RN support / Ongoing RN guidance
☐ Care Navigation & Coordination
☐ Patient & Caregiver Education
☐ Medication Understanding & Organization
☐ Assistance arranging services (home health, DME, etc.)
☐ Preparation for medical visits (PCP, urgent care, or specialist)
☐ Other: _____

List / Brief description of client concerns or goals:

_____
_____
_____

4. Medical History

Current Medical Conditions / Diagnoses: _____

Recent Hospitalizations or ER Visits: ☐ Yes ☐ No If yes, explain:

_____

Past Surgical History: _____

Current Medications (please list or attach if available): _____

_____

5. Social & Functional Status

Living Situation: ☐ Lives Alone ☐ Lives With Family ☐ Assisted Living ☐ Skilled Nursing Facility ☐ Other

Mobility Status: ☐ Independent ☐ Walker ☐ Wheelchair ☐ Requires Assistance

Other related concerns: _____

6. Primary Contact / Caregiver

Name: _____ Relationship: _____
Phone: _____ Email: _____

7. Urgency Level: ☐ Within 24–48 hours ☐ Within 3–5 days ☐ Routine / No Urgency

8. Insurance / Payment (Optional)

☐ Private Pay ☐ Long-Term Care Insurance ☐ Other: _____

Consent to Contact & Use of Information

I authorize Alice Esso Concierge Nursing LLC to contact me regarding concierge nursing services. I understand that the information provided will be used solely for care coordination and support services and will be handled in accordance with privacy and confidentiality standards.

*This service does not provide emergency care. If you are experiencing a medical emergency, call **911** or seek immediate medical attention.*

CLIENT/REPRESENTATIVE NAME (PRINT)**:** _____

SIGNATURE: _____ **DATE:** _____