



Baton Rouge

Sickle Cell Anemia Foundation

CLIENT ASSESSMENT FORM

PERSONAL INFORMATION

Type of Sickle Cell Disease: _____

Name: _____

Name of Parent/Guardian, if applicable: _____

Address: _____

State: _____ **Zip Code:** _____ **Parish:** _____

Contact Information: Telephone Numbers: Home/Work/Cell
_____ / _____ / _____

E-mail address: _____

Date of Birth: ____/____/____ **Social Security Number:** _____
(provide copy of birth certificate) (provide copy of social security card)

(check one)
Marital Status: ____ Single ____ Married ____ Divorced ____ Widowed

(check one) (check one)
Race: ____ Black ____ White Other _____ **Sex:** ____ M ____ F

If client is a student, indicate school: _____

FINANCIAL INFORMATION – Provide proof of income.

Total employment income: \$ _____ **Do you receive any of the following:**
____ SSI? ____ Social Security? ____ Disability?

Other family income: \$ _____

Total benefits income: \$ _____

Total household income: \$ _____ **Number of persons living in household:** _____

Does family receive food stamps: ____ Yes ____ No **Amount:** \$ _____

MEDICAL INFORMATION – Provide copies of medical/insurance cards.

Medicaid Number: _____ Medicare Number: _____

Other Medical Insurance: _____ Yes _____ No Name of Company: _____
Policy Number: _____

Number of persons living in household with sickle cell trait: _____

Number of persons living in household with sickle cell disease: _____

Family Members: include both parents

<u>Name</u>	<u>Age</u>	<u>Sex</u>	<u>Disease/Trait</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Doctor's Name: _____

Hospital currently used: _____

List current medications:

SERVICE INFORMATION

Member of support group? _____ Yes _____ No Attend meetings? _____ Yes _____ No

Name of support group: _____

What services will you require?

Date: _____ Client's Signature _____

