



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 \_\_\_\_\_

