TriBeCa Care Pvt. Ltd.
2A, Ramesh Mitra Road, Bhowanipur, Kolkata-700 025
Ph: +91 33 402 777 77
E-mail: enquiry@tribecacare.com
Website: www.tribecacare.com

REGISTRATION FORM: ELDER CARE PACKAGES

I)KNOWING THE MEMBERS: MEMBER INFORMATION

Name of 1st Member: Mr ☐ Mrs ☐ Ms ☐ Dr ☐

First Name: ☐ Middle Initial ☐ Last Name: ☐

Date of Birth: D D M M Y Y Sex: Male ☐ Female ☐ Ph: ☐

E-mail: ☐

Name of 2nd Member: Mr ☐ Mrs ☐ Ms ☐ Dr ☐

First Name: ☐ Middle Initial ☐ Last Name: ☐

Date of Birth: D D M M Y Y Sex: Male ☐ Female ☐ Ph: ☐

E-mail: ☐

Mobile: ☐ Phone: ☐

Name of 3rd Member: Mr ☐ Mrs ☐ Ms ☐ Dr ☐

First Name: ☐ Middle Initial ☐ Last Name: ☐

Date of Birth: D D M M Y Y Sex: Male ☐ Female ☐ Ph: ☐

E-mail: ☐

Mobile: ☐ Phone: ☐

Address: ☐

☐ Floor: ☐ Pin Code: ☐

Landmark: ☐ Lift Available: ☐ Y ☐ N

II)Emergency Details:

Member needs 24X7 Ambulance Facilitation Services? ☐ Y ☐ N
Member needs Hospitalisation Help Services? ☐ Y ☐ N

Contact #1 Kolkata based Relative or Responsible Friend / Neighbour
Name: ☐

Address: ☐

Mobile Number: ☐
Relationship with Senior Citizen: ____________________

Can be contacted at night: ☐ Y ☐ N

Contact #1 Kolkata based Relative or Responsible Friend / Neighbour
Name: ☐
Address: ☐
Mobile Number: ☐
Relationship with Senior Citizen: ____________________
Can be contacted at night: ☐ Y ☐ N

Important Contact Details:

a) Primary Contact Person/Next of Kin: ☐ Mr ☐ Mrs ☐ Ms ☐ Dr

Name: Mr ☐ Mrs ☐ Ms ☐ Dr ☐

First Name: ☐ Middle Initial ☐ Last Name: ☐

E-mail: ____________________ Phone: ☐

Mail address ☐

☐

b)Primary Physician: (Member 1)

Speciality Phone:

Hospital/Nursing Home associated with:

c)Primary Physician: (Member 2)

Speciality Phone:

Hospital/Nursing Home associated with:

d)Primary Physician: (Member 3)

Speciality Phone:

Hospital/Nursing Home associated with:

e)Other Physician:

Speciality Phone:

Hospital/Nursing Home associated with:

f)Preferred hospitals for Emergency situations:

1)

2)

3)

4)

g)Insurance Details:

1st Member

a)Company

b)Policy Number

c)Policy Details

d)Photocopy of Policy Provided: Y N

2nd Member

a)Company

b)Policy Number

c)Policy Details

d)Photocopy of Policy Provided: Y N

3rd Member

a)Company

b)Policy Number

c)Policy Details

d)Photocopy of Policy Provided: Y N

III) Environmental Factors

How many people in the house? (Age/Relationship)	General home condition for patient safety (Bathroom, Fall risk, etc.)	Neighbourhood safety (e.g. are the neighbours friendly, what happens for an emergency response situation)	Do the members need adult companionship or caretaker, if living alone?	Other Issues

IV)TriBeCa Care Packages:

Name of Package		Annual Registration Fee	Monthly Fee
1) Aador	☐	7100	7100
2)Jotno	☐	5100	3200
3)Suraksha	☐	1500	1500
4)24-Ghonta	☐	1500	800

DECLARATION :

I give my consent to Tribeca Care Pvt Ltd to care for the above mentioned members/dependents, to arrange for routine or emergency medical and/or dental care and treatment necessary to preserve the health of the member. In the event that the member is injured or ill while under the care of the caregiver, I hereby give permission to the caregiver to provide first aid for said dependent and to take the appropriate measures, including contacting the emergency medical service and arranging for transportation to the nearest emergency medical facility.

In making medical decisions on my behalf for the benefit of my dependent, I direct that the caregiver attempt to contact me. However, if medical care becomes essential, I give permission to the caregiver to make such decisions regarding such treatment as deemed appropriate by the medical doctor, hospital or their authorized designee. In furtherance of any treatment decisions to be made by the caregiver on my behalf for the benefit of my dependent/member, I authorize the caregiver to request, obtain, review and inspect any and all information bearing upon my dependent's health and relevant to any such decisions to be made respecting such treatment.

I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on the condition of my dependent/member and that I am responsible for all reasonable charges in connection with the care and treatment rendered to my dependant/member during this period.

I have the valid power and authority to represent the Member/s, and agree to the Tribeca Care's Standard Terms and Conditions.

Member or Family Friend:

Date:

Membership Start Date:

Membership End Date:

Signature and Name of TriBeCa Personnel:

FOR OFFICE USE ONLY

TriBeCa Care Manager Visit Preference:

Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐

Monthly Visits: Once ☐ Twice ☐ Four Times ☐ Eight Times ☐ Twelve Times ☐

Morning Visit ☐ Afternoon Visit ☐ Evening Visit ☐

Type of care needed	**Ayah**	**Nurse**	**Physiotherapist/ Other (e.g., Nutritionist, Yoga Instructor, Errand)**	**Doctor Visit/ Phone Consultation**	**Emotional Companionship**	**24-hr Caretaker**
Please provide details of kind of care needed (e.g. Shifts, Visits, Frequency etc.)						

Other Requirements:

Service	**Details**						
Doctor Home Visits							
Doctor on Phone							
Nurse Oversight							
Medicine							
Equipment							
Diagnostics							
Others							

Staircase: Broad ☐ Narrow ☐

IDENTITY PROOF / ADDRESS PROOF (Any two of below documents)

Pan Card / Driver's License / Voter's ID Card / Passport / Aadhaar Letter / Valid Passport

MEMBER GET MEMBER

NAME	PHONE NUMBER	ADDRESS
1		
2		
3		

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MEDICAL ASSESSMENT FORM

Name of 1st Member: Mr ☐ Mrs ☐ Ms ☐ Dr ☐

First Name: | Middle Initial | Last Name:

DETAILED MEDICAL CONDITION

Diagnosis/Problems: (e.g. Acute breathlessness, Diabetes, etc.)

Detailed observations to be made in below section

Require assistance to move	Needs assistance with all activities	Confusion
Residual Weakness	Medical/Clinical Concerns	Others

Diet/Nutritional Restrictions:

Height: | Weight: | General: | Condition:

Temperature: | Pulse Rate: | Blood Pressure (S/D):

Mental State (observations):

FUNCTIONAL LIMITATIONS	ACTIVITIES PERMITTED	MENTAL STATUS	HELP NEEDED	CHRONIC CONDITIONS
Bowel/Bladder	Complete Bedrest	Oriented	Bathing	COPD
Hearing	Exercise Needed	Comatose	Dressing	Diabetes
Paralysis		Forgetful	Toileting	Pain
Speech	**Assistive Devices**	Depressed	Feeding	Chronic Wounds
Ambulation	Crutches	Disoriented	Meal Prep	Ulcers
	Cane	Lethargic	Shopping	Dementia
	Wheelchair	Agitated	Medication	Renal
	Walker	Others	Others	Others
	Others			

Medications

NAME	DOSE	FREQUENCY	OTHER COMMENTS	NAME	DOSE	FREQUENCY

Customer Signature **DATE:**

TriBeCa Personnel