INTAKE/REFERRAL FORM

Date of Referral: ____________________ MR#: ____________________________ Date: _________________________

HIC#: ______________________________ Eff. Date: __________________ Referral Source: ______________________

Secondary Ins.: ____ Group: ___________________________

Patient: ____ Phone: ___________________________

DOB: ____ Age: ________ Race: __________ Sex: ________

Address: ____ City/State/Zip: ______________________________________
patient's permanent address

Address: ____ City/State/Zip: ______________________________________
address to visit patient

#1 Physician: ______________________________ Phone: ____________________ Specialty: _____________________

Address: ____ City/State/Zip: ______________________________________

#2 Physician: ______________________________ Phone: ____________________ Specialty: _____________________

Address: ____ City/State/Zip: ______________________________________

Verbal Order: ____ (date/time/source/signature)

Hospital: __________________________________ Room #: ____________ Adm: _____________ D/C: _____________

Emergency Contact/Next of Kin: ____

P/S	**Diagnosis**	**Code**	**Onset Date**

Surgical Procedure/Date: ____

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Serv.	**Frequency/Duration**	**Physician Orders: (i.e., wound, cath, ostomy)**
SN		
Aide		
Other		

Signature: ____

Title: ____ Date: ___________________________

INTAKE/REFERRAL FORM (continued)

Pharmacy: ______________________________ Phone: ______________

Allergies: ______________________ Diet: ______________________

DME/Supplies: ____

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Medications: (N) New (C) Change ______________________________

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Safety Measures:
- ❑ Cardiac Prec.
- ❑ Diabetic Prec.
- ❑ HTN Prec.
- ❑ O_2 Prec.
- ❑ Standard Prec.
- ❑ Prevent Falls
- ❑ Psychiatric Prec.
- ❑ Maintain Safe Environment
- ❑ Pulm/Resp Prec.
- ❑ SAN Prec.
- ❑ Neurological Prec.
- ❑ Other: ______________________

Functional Limitations:
- ❑ Amputation
- ❑ Paralysis
- ❑ Legally Blind
- ❑ Bowel/Bladder
- ❑ Endurance
- ❑ Dyspnea w/minor exertion
- ❑ Contracture
- ❑ Speech
- ❑ Hearing

Activities Permitted:
- ❑ Comp. Bedrest
- ❑ Bedrest BRP
- ❑ Up as Tolerated
- ❑ Part. Wt. Bearing
- ❑ Independent
- ❑ Wheelchair
- ❑ Walker
- ❑ Cane
- ❑ Crutches
- ❑ Transfer
- ❑ Exercise
- ❑ Other: ______________________

Mental Status:
- ❑ Oriented
- ❑ Forgetful
- ❑ Disoriented
- ❑ Agitated
- ❑ Comatose
- ❑ Depressed
- ❑ Lethargic
- ❑ Alert
- ❑ Other: ______________

Prognosis:
- ❑ Poor
- ❑ Guarded
- ❑ Fair
- ❑ Good
- ❑ Excellent

Chief Complaints (Hospital/Dr. Office): ______________________________

Hospital Stay: Significant PMH/Labs/Procedures/Results/VS Range: ______________

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Initial Visit: ____

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10.07.05.08 B(1)(a)(v)