



INTAKE FORM

UPDATED INTAKE (only complete patient name & updated information)

30 DAY REVERIFICATION (Name & DOB only)

FAX _____ REPRESENTATIVE _____ DATE _____

PATIENT INFORMATION					
Patient Name		<input type="checkbox"/> Male <input type="checkbox"/> Female		Phone	
Scheduling contact if other than patient			Relationship to patient		Phone
Address		City	State	Zip	Rm # or Gate Code
Is patient currently in an assisted living facility? <input type="checkbox"/> Yes <input type="checkbox"/> No If YES, name of ALF			Name of ALF Care Coordinator		
POA			Phone		
Billing Address		City	State	Zip	Rm # or Gate Code
Notes:					
Please include: HPI, Past Medical History, and Wound Location.					
INSURANCE INFORMATION **Please include copy of insurance card/s**					
Primary Insurance		Member ID		Phone	
Secondary Insurance		Member ID		Phone	
REFERRAL SOURCE					
Source		Point of Contact		Phone	
HOME HEALTH PARTNER					
Name		Phone		Order Fax	
If no current HH, is there a preferred HH? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name		Phone	
Case Nurse		Phone	DON		Phone
OTHER PARTICIPATING CARE PARTNERS					
Primary Care Physician		Phone		Point of Contact	
Requesting Clinical Notes? <input type="checkbox"/> Yes <input type="checkbox"/> No			Fax		
Skilled Nursing		Phone	Discharge Coordinator		Phone
SUSPECTED WOUND ETIOLOGY (IF AVAILABLE)			EXAMPLE: Place "X" over area of wound		
Check as many as you may suspect apply					
<input type="checkbox"/> Venous stasis <input type="checkbox"/> Post thrombotic <input type="checkbox"/> Diabetic Ulcer <input type="checkbox"/> Burn <input type="checkbox"/> Non-healing traumatic (e.g. resulting from a fall) <input type="checkbox"/> Post surgical (include procedure if known) <input type="checkbox"/> Pressure injury Has this wound been treated by healthcare professionals? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, for what period of time? <input type="checkbox"/> <30 days <input type="checkbox"/> 30-90 days <input type="checkbox"/> >90 days					
OTHER RELEVANT CONDITIONS					
Check as many as you may suspect apply					
<input type="checkbox"/> Diabetes <input type="checkbox"/> Hypertension <input type="checkbox"/> Venous Insufficiency <input type="checkbox"/> Malnutrition <input type="checkbox"/> Moderate to severe mobility restriction <input type="checkbox"/> Edema (including lymphedema) <input type="checkbox"/> Arterial Insufficiency <input type="checkbox"/> Suspected infection at the wound site					