



REFERRAL AND INTAKE FORM

Patient ID#: _____

PATIENT NAME: _____ Tel.#: _____

Address: _____ Apt. #: _____

Borough: _____ Zip Code: _____ Cross Street: _____ Floor #: _____

DOB: _____ Age: _____ Sex: M F Marital Status: S M W D Sep.

Lives with: _____ Relationship: _____ Other Tel.#: _____

Emergency Contact Name: _____ Relationship: _____ Tel.#: _____

Language: Eng Span Ydsh Russ Fren Other _____ Translator Needed: Yes No

Date of Inquiry: _____ SOC Date: _____ Intake by: _____

Referral Source: _____

Person Making Referral: _____ Tel.#: _____

Requested Services: _____

Is the Patient receiving HHC services? Yes No If yes, Home Health Agency: _____

Type and frequency of service: _____

Current location of Patient: Home SNF/Rehab Hospital Other _____

Name of Institution: _____

Admission Date: _____ Discharge Date: _____ Hosp. Admitting Diagnoses: _____

INSURANCE INFORMATION: Homebound: Yes No Social Security #: _____

Medicare #: _____ Medicaid #: _____

Private Pay (deposit required) Amount: _____ Contact Person: _____

Address of Contact Person: _____ Tel.#: _____

Diagnoses/Date(s) of Onset of DM (if applicable) _____

Surgical Procedure(s)/Date(s): _____ Allergies: _____

Primary MD: _____ UPIN#: _____ Lic.#: _____

Tel #: _____ Fax: _____

GD / VZ

Revised: 2/09



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PATIENT NAME: _____

List all medications (prescription and over the counter / herbal): _____

Function Status: Ambulatory Cane/walker W/C Bedbound

Mental Status: Alert Oriented: x1 x2 x3 Disoriented Forgetful Confused

Mood: Cooperative Suspicious Other: _____

Nutritional Status (Diet): _____ Supplements: _____

Fluid Restriction: _____ Amount of fluid per day: _____

Sensory Deficits: Visual Speech Hearing Extremities
 Glasses Vocalization Device Hearing Aid Prosthesis

Disciplines Involved: RN LPN HHA CNA OT PT ST MSW Nutritionist

Therapist/Vendor: _____

HHA/Vendor: _____

Family/Caregivers to be present: Yes No If Yes, Who? _____

Location of Service: Home SNF Other: _____

Are there any pets/animals in patient's place of care? Yes No If Yes, describe: _____

Does the patient smoke? Yes No If yes, How many packs a day? _____ Smoking in the house? Yes No

Any allergens? _____ Other Information: _____

COORDINATOR SIGNATURE / TITLE

DATE

GD / VZ

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