ACCESSIBLE HOME CARE, LLC

131 N. Santa Fe Suite 110, Salina, Kansas 67401
Agency Phone: (785) 493-8111 Agency Fax: (785) 493-8002

REFERRAL / INTAKE FORM

Name: _____
Address: _____
_____
City/State/Zip:_____
Phone:_____
Referral Source: _____
Hospital: _____

DOB:_____
SSN:_____
SEX: M/F Race: _____
Marital Status: M S D W
Insurance: _____
ID number: _____
Auth number: _____

Principal DX:	Date of O/E
Secondary DX:	

Surgical Procedures: _____ Date: _____
Functional Limitations: ☐ Speech ☐ Paralysis ☐ Hearing ☐ Vision
Amputation: extremity involved: RUE LUE RLE LUE
Activities Permitted: UAT Bed Rest Trans only BRP
Weight Bearing Status: Full Partial none Assistive Devices Y/N _____
Foley Catheter: Y/N Size:_____ Date inserted: _____ Last changed: _____

Diet:	Allergies:
Lab Orders: Frequency:	Emergency Contact Name: Contact number:
Services Ordered: SN: _____ HHA: _____ PT: _____ OT: _____ ST: _____	Notes: Med changes Y/N

Ordering Physician:	Primary Physician:
PCP address/phone/fax:	
Admitting orders:	
Intake nurse signature:	Date:
Patient admitted Y/N If no: referral source notified Y/N Reason for non-admit:	