Allied Health Systems, LLC. Referral/Intake Form; Fax To: 413.304.2667

	☐ Medicare ☐ Medicaid ☐ Other _____	☐ New Admit ☐ Resumpt/existing SOC ☐ Readmit/New SOC ☐ Not Admitted	Referral Source_____ Ref Phone:_____ Referral Date_____ Hosp. DC Date_____ SOC_____ Info taken by_____

Patient Info

Name *(Last, First)*:_____
DOB_____ Age_____ Sex:_____ Lives With: _____
Address:_____
City/State/Zip:_____ Phone:_____
SSN: _____ Languages Spoken: _____
Emergency Contact:
Name:_____ Relationship:_____
Address:_____
City/State/Zip:_____ Phone: _____

Generic Info.

Physician (Primary)	Address	Phone #
Physician (Spec)	Address	Phone #
Hospital	Referred By	Phone #

Billing

Medicare #	Effective Dates	Private Ins. Co.
Medicaid #	Effective Dates	Policy#/Group #:
☐ Private Pay		Subscriber:

Diagnosis/History

Primary Diagnosis	ICD-9	Onset/Exac	Hosp. Admit date

Hospital Course
_____
_____
_____

DX	O/E	ICD-9	DX	O/E	ICD-9	Ht	Wt
						Current Vs	
						Pertinent labs	

Supplies/DME Needed:

Orders

Disciplines/Freq
☐ RN
☐ LPN/VN
☐ PT
☐ OT
☐ ST
☐ HHA
☐ PCA
☐ Other

Services Requested (Specify discipline, frequency/duration, treatments)
_____
_____
_____
_____
_____
_____
_____
_____
_____

☐ Up as tol
☐ Bed rest
☐ Transfer/BC
☐ Walker
☐ Wheelchair
☐ Cane:_____
☐ Crutches
☐ Wt Bearing____
ADL's
☐ Independent
☐ Dependent

Rehab Potential
☐ Excellent
☐ Good
☐ Fair
☐ Guarded
☐ Poor

Medications

Drugs (N)ew (C)hanged	Dose/Route/Frequency	Drugs (N)ew (C)hanged	Dose/Route/Frequency

Miscellaneous

_____
_____
_____
_____
_____
_____

Mental:_____
Diet:_____
Hearing:_____
Vision:_____
Speech:_____
Incont. ☐ Bowel ☐ Bladder
Allergies: _____

Staff Assigned:
SN:_____ ST:_____
PT: _____ Aide/HMK:_____
OT:_____ MSS/MSW:_____