Order Intake Form

Date: ____/____/____ Time: _________ AM/PM
Referral: ____________________________________

Customer Service Rep: ___________________
Phone: ________________________________

Patient Information

Name: ____________________________________
Address: __________________________________

Sex: M F Date of Birth: ____/____/_____
City: ____________________ ZIP: _________

Is this the patient's permanent address? YES NO

SSN: ___________________________

Emergency Contact: ___________________________

Phone: ________________________________

Physician Information

Primary Physician: ______________________________
Address: ____________________________________

Phone: _____________ UPIN: _____________
City: ____________________ ZIP: _________

Primary Physician: ______________________________
Address: ____________________________________

Phone: _____________ UPIN: _____________
City: ____________________ ZIP: _________

Insurance Information

Primary Insurance: _____________________________
Insurance Address: _____________________________
Policy Holder: _________________________________

Phone: ________________________________
City: ____________________ ZIP: _________
Policy and Group Number: _________________

Secondary Insurance: ___________________________
Insurance Address: _____________________________
Policy Holder: _________________________________

Phone: ________________________________
City: ____________________ ZIP: _________
Policy and Group Number: _________________

Deductible Met? YES NO Authorization Required? YES NO *If YES, List Number:* _________

Diagnosis Information (Include ICD 9 Code)

Primary Diagnosis: _____________________________
Secondary Diagnosis: ____________________

Physician's Orders: ____

[ ] O2 – LPM _____ HRS _____ Ambulation ________
[ ] ABG: _____ O2 Saturation: _____% Test Date: _________ Where: __________________________
[ ] Wheelchair: ___________________ Height: ____________ Weight: ___________
[ ] Other Equipment: ____

Other Information

Has the patient rented HME equipment before? YES NO (If yes, list items and dates: ____________________)
Has the patient had home care services before? YES NO (If yes, list services and dates: ____________________)
Does patient own medical equipment? YES NO Are other agencies involved? YES NO (If yes, list: ____________________)
Is injury or illness work related? YES NO (If yes, list date of injury: ______/______/________)
Is there a language barrier or physical limitation (e.g., sight, hearing)?
Is patient or spouse enrolled in an HMO? YES NO
Medicare patient or spouse employed? YES NO

Is patient aware of deductible or copy? YES NO
Does the patient live alone? YES NO