Intake Form

Save

Referral Source:

Therapist: Referral Phone: Intake Date: Sales Rep:

Client Information

Client Name (First, Middle, Last): SS#:

Street 1: DOB:

Street 2: Sex:

City: State: ZIP: Prognosis:

Client Phone: Resp. Pty: Length of Need (months):

Resp. Party Address: Equip. New, Rent, Other:

Resp. Pty Phone (H): Resp. Pty Phone (W):

Diagnosis Code 1: Diagnosis Description 1:

Diagnosis Code 2: Diagnosis Description 2:

Diagnosis Code 3: Diagnosis Description 3:

Diagnosis Code 4: Diagnosis Description 4:

Client Height: Ft In Overall Weight: lbs

Insurance Information

Primary Carrier: Phone #:

Insured Name: Contact:

Insured ID#:

Group #:

Secondary Carrier: Phone #:

Insured Name: Contact:

Insured ID#:

Group #:

Tertiary Carrier: Phone #:

Insured Name: Contact:

Insured ID#:

Group #:

Physician Information

☐ PECOS Certified

Name: Phone #:

Street 1: Fax #:

Street 2: UPIN #:

City: State: ZIP: License #:

NPI #:

Facility Information

Organization:		Phone #:	
Street 1:		Fax #:	
Street 2:		Therapist Name:	
City:	State: ZIP:	Date of Eval:	
NPI #:			

Company Name and Address:

Company Ship To Name and Address:

Company Bill To Name and Address:

Patient's Current Equipment (Select Items For This Order):

Manufacturer	Model	Serial #	Description	

Order Notes: