

# EXCEL HEALTH CARE SERVICES

## INTAKE/REFERRAL FORM

Date of Referral: \_\_\_\_\_

Date: \_\_\_\_\_

Eff. Date: \_\_\_\_\_

Referral Source: \_\_\_\_\_

Insurance: N/A

Group: N/A

Patient: \_\_\_\_\_ Phone: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Race: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Patient's permanent address

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Verbal Order: \_\_\_\_\_ (date/time/source/signature)

Emergency Contact/Next of Kin: \_\_\_\_\_ Phone: \_\_\_\_\_

Serv.	Frequency/Duration	
SN		
PT		
OT		
Aide		

Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_

Allergies: \_\_\_\_\_ Diet: \_\_\_\_\_

DME/Supplies: \_\_\_\_\_

Medications: (N) New (C) Change \_\_\_\_\_

# EXCEL HEALTH CARE SERVICES

## Check the Appropriate Choice:

**Living Arrangement:**     Pt. Lives Alone     With Family. \_\_\_\_\_

**Safety Measures:**     Cardiac Prec.     Diabetic Prec.     HTN Prec.     O<sub>2</sub> Prec.     Standard Prec.  
 Prevent Falls     Psychiatric Prec.     Maintain Safe Environment     Pulm/Resp  
Prec.

SAN Prec.     Neurological Prec.     Other: \_\_\_\_\_

**Functional Limitations:**     Amputation     Paralysis     Legally Blind     Bowel/Bladder     Endurance  
 Dyspnea w/minor exertion     Contracture     Speech     Hearing

**Activities Permitted:**     Comp. Bed rest     Bed rest BRP     Up as Tolerated     Part. Wt. Bearing  
 Independent     W wheelchair     Walker     Cane      
Crutches

Transfer     Exercise     Other: \_\_\_\_\_

**Mental Status:**     Oriented     Forgetful     Disoriented     Agitated     Comatose  
 Depressed     Lethargic     Alert     Other: \_\_\_\_\_

**Code Status:**     Full Resuscitation– (Full Code)     Do Not Resuscitate– (No Code)  
 Do Not Resuscitate/Palliative Care– (No Code, Administer Palliative Care) Treatments  
Providing comfort will continue. Other treatments may be withheld if they do not  
Contribute to the goal of providing comfort, or if they cause discomfort.

Do Not Intubate– Resuscitate short of Intubation – (Full Code, No Intubation)

The following resuscitation measures will be carried out unless crossed out:

• CPR • Defibrillation • Drugs • Bag and Mask

**Prognosis:**     Poor     Guarded     Fair     Good     Excellent

Chief Complaints (Hospital/Dr. Office): \_\_\_\_\_

Hospital Stay: Significant PMH/Labs/Procedures/Results/VS Range: \_\_\_\_\_

Initial Visit : \_\_\_\_\_