

ORDER INTAKE / INITIAL ASSESSMENT

Date: _____	Who Called/Came In: _____
Time: _____	Phone: _____
Taken By: _____	Hospital: _____ Room #: _____
Patient's Name: _____	Sex: _____
Address: _____	Height: _____
_____	Weight: _____
Phone: _____	Date of Birth: _____
Medicare Part B #: _____	Medicaid #: _____
Private Insurance: _____	Policy#: _____
Address: _____	_____
_____	Phone(s): _____
Deductible Met?: _____	Subscriber Name DOB: _____
Relationship: _____	Does patent have a DNR if applicable? _____
Private Insurance: _____	Policy # _____
Address: _____	_____
_____	Phone(s): _____
Deductible Met? _____	Subscriber Name DOB: _____
Relationship: _____	Does patent have a DNR if applicable? _____
Pt. Previously rented/purchased same or similar Equipment? _____	
If yes please explain: _____	
Physician: _____	Item(s) Needed: _____
Address: _____	_____
UPIN: _____	_____
Phone(s): _____	If O ₂ PO ₂ _____ O ₂ Sat _____ Liter Flow _____
Office contact: _____	Diagnosis: _____
How Long Equipment Needed: _____	_____
Mental Status: _____	
Functional Status: _____	
Home Environment: _____	
Condition: _____	
Can Pt. Understand directions? _____ Financial Hardships? _____	
Does the patient require reassignment or further training? _____	
Explain: _____	

Caregivers Name _____ Relationship _____	
Phone(s) _____	

ADDITIONAL NOTES ON REVERSE SIDE

