Scott's Home Healthcare, LLC INTAKE/REFERRAL

*** Patient Name:**_____ **Date of Referral:**_____

Address:_____ **Completed by:**_____

City:_____ **(*County)***_____ **State**: IN **Zip**_____

(*Referral Source*):_____

Phone:_____ ***(Sex)*:** **Male**_____ **Female**_____

SSN:_____ **Marital Status: M ___ S___ D___ W___**

*** DOB:**_____ ***(Age)*:**_____

Primary Physician: _____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Phone:_____ **Fax:**_____

Emergency Contact Name: _____

Address:_____

City: _____ **State:**_____**Zip:**_____

Phone:_____ **Cell:**_____

Relationship_____

(*Primary Diagnoses*):_____
_____
_____
_____

Diet/Nutritional Needs_____

Height_____ **Weight:**_____ **Allergies:**_____
Additional Information_____
_____

Projected Services: **SN____ HHA____ PT____ OT____ ST____**

(*Payer Information*):

MEDICARE #_____

*** MEDICAID#**_____

OTHER_____

Directions to home: _____
_____
_____

Pre-Admission Notes: _____
_____
_____