Intake Form

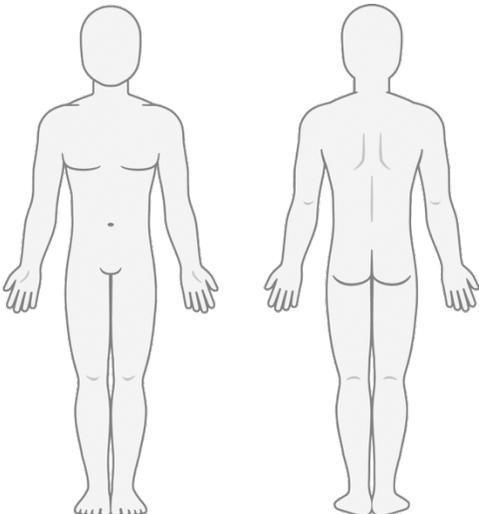## Intake Type
❏ New Patient Intake   ❏ Updated Patient Information   ❏ 30-Day Reverification (Name & DOB only)

Patient Information		
Name	Sex ❏ Male ❏ Female	D.O.B.
Phone	Address	
Current Setting ❏ SNF ❏ ALF ❏ Private Residence	Primary Contact/ POA (if applicable):	

Insurance Information		
Primary Insurance	Insurance Number	Coverage Type
Secondary Insurance	Insurance Number	Coverage Type

Coverage Type: **1.** *Traditional Medicare*   **2.** *Medicare Advantage.*   **3.** *Commercial*
Attach copy of insurance cards

Referral Source

Referring Facility/ Organization	Facility Type ❏ SNF ❏ Hospital ❏ Home Health ❏ Other
Referring Contact Name	Referring Contact Phone

Home Health/ Care Coordination Partner

Current Home Health Agency (if applicable):	Case Manager/ DON:

Other Participating Providers

Primary Care Provider:	Hospital/ Transitions Team (if applicable)

Wound Etiology (Check all that apply)

❏ Diabetic   ❏ Post-Surgical   ❏ Chronic/ Non-Healing (>30 days)
❏ Pressure Injury   ❏ Trauma
❏ Venous   ❏ Burn   ❏ Recurrent Wound

Duration of Current Wound

❏ <30 days   ❏ 30-90 days   ❏ >90 days

Using the drawing tools, mark the affected area(s) on the body diagram.

Comorbidities (Check all that apply)

❏ Diabetes   ❏ Limited Mobility
❏ Hypertension   ❏ Infection Risk
❏ Venous Insufficiency   ❏ Recent Hospitalization
❏ Malnutrition   (last 30 days)

Additional Notes - Clinical Details