PRECISE HOME HEALTH

Office: 602-428-1773 **Mobile:** 470-710-3797 **Fax:** 470-712-4996
Email: info@precisehomehealthllc.com **Website:** precise-homehealth.com

REFERRAL / LEAD INTAKE FORM

Intake Person Name: _____ Date: _____ Time: _____

How did you hear about us? _____

CALLER

Caller Name: _____

Relation to Client: ☐ Daughter/Son ☐ Spouse ☐ Power of Attorney (POA) - Financial ☐ Power of Attorney (POA) - Medical ☐ Other: _____

Email: _____ Phone: _____ Cell: _____

Phone Numbers if other than Caller or Client: _____

Address: _____ City: _____ Zip: _____

CLIENT

Name: _____ DOB: _____ Age: ____ ☐ Male ☐ Female

Address: _____ City: _____ Zip: _____

SERVICES NEEDED

☐ Dementia Care / Level or Type: _____ ☐ Transportation: _____

☐ Ambulation / Transferring: _____ ☐ Toileting: _____

☐ Weight: _____ ☐ Bathing: _____

☐ Med Reminder: _____ ☐ Incontinence: _____

☐ Meals / Feeding: _____ ☐ Dressing: _____

PAYMENT SOURCE INFORMATION

Payment Options:

☐ Private Pay ☐ Insurance ☐ Medicaid
☐ Medicare ☐ VA Insurance

Are you a veteran? ☐ Yes ☐ No -If Yes

Are you a wartime Vet? ☐ Yes ☐ No

- ☐ WW2: Dec. 7, 1941-Dec. 31, 1946
- ☐ Korean: June 27, 1950-Jan. 31, 1955
- ☐ Vietnam: Aug 5, 1964-May 7, 1975; In Country before Aug 5, 1964; Feb 28, 1961-May 7, 195
- ☐ Gulf: Aug 2 1990 to Date TBD

Do you have a service connected disability?	☐ Yes ☐ No
Are you a spouse of a veteran?	☐ Yes ☐ No
Were you married when the Veteran passed away?	☐ Yes ☐ No
Are you on Medicaid?	☐ Yes ☐ No
Do you have a Medicare Advantage - Part C Plan?	☐ Yes ☐ No
What company?	
Do you have a long term care insurance policy?	☐ Yes ☐ No
Do you own your own home?	☐ Yes ☐ No

PRINCIPAL DIAGNOSIS:

SERVICES NEEDED

Additional Notes: _____