Patient Intake Form

Ensuring a Smooth Transition Home

Click Here to: Return form to Samara Crudup, M.D.

Patient Information

Full Name: _____

Date of Birth: _____

Phone Number: _____

Email Address: _____

Address: _____

City/State/Zip: _____

Emergency Contact

Name: _____

Relationship: _____

Phone Number: _____

Primary Concern / Reason for Consultation

Please describe your current situation and what support you are seeking:

_____

_____

Medical History

Recent Hospitalization or Surgery (within last 6 months):

☐ Yes ☐ No

If yes, please describe:

_____

Current Diagnoses / Conditions:

_____

Family Medical History:

Mother: _____

Father: _____

Sibling: _____

Grandparent: _____

Allergies & Symptoms: _____

_____

Care Team Information

Primary Care Physician: _____

Specialists (if applicable): _____

Home Health / Therapy Services: _____

Medications

Please list all current medications, supplements, or peptide therapies:

_____

_____

_____

Functional Status

Functional Status Prior to Recent Hospital Admission or Procedure:

_____

Current Functional Status: Symptoms or Concerns

_____

Mobility

☐ Independent

☐ Needs assistance

☐ Cane: circle one (straight, 3-point, 4-point/quad)

☐ Uses a walker: circle one (pick up walker, rolling walker, hemi)

☐ Uses a rollator

☐ Wheelchair

Activities of Daily Living (ADLs)

☐ Independent

☐ Needs some assistance

☐ Fully dependent

Cognitive Status

☐ No concerns

☐ Mild memory issues

☐ Moderate/severe impairment

Home Environment

Living Situation:

☐ Alone ☐ With family ☐ Caregiver support ☐ Facility

Home Setup:

☐ Single-level ☐ Multi-level ☐ Stairs present

Any safety concerns at home?

_____

_____

Goals for Care

☐ Safe transition home

☐ Reduce hospital readmission risk

☐ Improve mobility/function

☐ Medication / treatment guidance

☐ Care coordination / advocacy

☐ Other: _____

Patient Advocacy & Care Coordination Needs

☐ Understanding discharge instructions

☐ Coordinating care with providers

☐ Family/caregiver guidance

☐ Long-term care planning

☐ Other: _____

Peptide / Cellular Medicine Interest

☐ Yes ☐ No ☐ Not sure

Consent & Acknowledgment

I understand that Gericare Physiatry provides consultative and advocacy-based services and does not replace my primary medical providers.

Signature: _____

Date: _____

Optional: Caregiver Input

Name: _____Relationship: _____

Key concerns or observations:

_____