

Iowa Mobile Medical 	Iowa Mobile Medical - Patient Intake Form	
	Questions: 888-774-2282	Send Referrals to: Email: Info@lowamobilemedical.com Or Fax: 515-630-0535

Referring Partner

* Name	Phone	Email
* Referring Clinic/Agency	Phone	* Fax
Scheduling Contact	Scheduling email	Scheduling Fax
Scheduling Phone	Preferred method of contact for response: Phone AND <input type="checkbox"/> Email or <input type="checkbox"/> Fax	
* PCP	PCP Phone	* PCP Fax
PCP Clinic: Address, City, State, Zip		

PATIENT INFORMATION

* Patient Name	* Phone	* DOB
* Address, City, State, Zip		
Power of Attorney	Phone	Email
<input type="checkbox"/> Private Residence <input type="checkbox"/> Assisted Living <input type="checkbox"/> Skilled Nursing <input type="checkbox"/> Group Home <input type="checkbox"/> Long Term Care <input type="checkbox"/> Other _____ Patient Aware of Referral to Iowa Mobile Medical? YES or NO (Circle one)		

INSURANCE INFORMATION – Please attach a copy of the patient’s insurance cards

* Primary Insurance	* Member ID	Phone
Secondary Insurance	Member ID	Phone

WOUND 1– Please Describe

Type	Severity	Location
Previous treatment tried and failed		

WOUND 2- Please Describe

Type	Severity	Location
Previous treatment tried and failed		

Please send the information below with your referral. Once we receive the information, we will begin insurance approval process and scheduling the patient visits.

<input type="checkbox"/> Copy of Insurance cards	<input type="checkbox"/> Photos of wound (if available)
<input type="checkbox"/> Date of Referral:	<input type="checkbox"/> Documentation of treatment

**ATTENTION: CASE MANAGERS, DISCHARGE PLANNERS, REFERRAL COORDINATORS AND UTILIZATION MANAGERS
 ALL ITEMS MARKED WITH (*) ARE REQUIRED**