INTAKE REQUEST*

Equity Services of St. Paul, Inc.
1169 Rice Street Phone: 651-489-4656
St. Paul MN 55117 FAX: 651-489-4811

***Please Note: An intake request that is filled out and faxed to us is not an acknowledgement of any acceptance of services until approved by Director of Nursing.**

Date: _____

Refered by: _____

CLIENT:

Name: _____

Date of Birth: _____ Male Female

Address: _____

City: _____ Zip _____

Phone: _____

Language: _____ Interpreter:_____

Emergency Contact: _____

_____

Alt. Emergency Contact: _____

Code Status: _____

Smokes: _____ Pets: _____

Lives With: _____

Diagnosis: ICD-9 Date of Onset

_____

_____

_____

_____

Allergies: _____

Pneumonia Vaccine: _____ Flu Shot: _____

Financial:

Social Security Number: _____

Medicare Number: _____

MA (PMI): _____

Payor Type: _____

Payor Number: _____

MD

Name: _____

Clinic: _____

Address: _____

_____

Phone: _____

Fax: _____

MD

Name: _____ Clinic: _____

Address: _____

_____

Phone: _____ Fax: _____

Phone Number: _____

Case Manager: _____

Phone: _____

Fax: _____

Hospital Last 14 days? Yes No Preference _____

Nursing Home last 14 days? Yes No

Pharmacy preference: _____

Pharmacy Number: _____

Pharmacy Fax: _____

Other Homecare involved:_____

Other Helpful Information: _____

_____

Discipline

Nursing: _____

_____

HHA: _____

_____

PCA: _____

_____

HMKR: _____

Other: _____

FOR OFFICE USE ONLY

____ ACCEPTED DATE: _____

CHART NUMBER: _____

Telephone Order Sent Date: _____

INTAKE ASSIGNED: _____ Date: _____

Estimated Start Date: _____

____ NOT ACCEPTED

____ Could not staff

____ MD refused to sign orders

____ Client refused services

____ Client went to another agency

____ Other