STARLITE CARE, INC.

INTAKE/REFERRAL FORM

FAX COMPLETED FORM TO (301) 885 - 0497

Date of Referral: _____ Date: _____

Eff. Date: _____ Date: _____

Secondary Ins.: _____ Group: _____

Patient: _____ Group: _____

DOB: _____ Age: _____ Race: _____ Sex: _____

Address: _____ City/State/Zip: _____
Patient's permanet address

Address: _____ City/State/Zip: _____
Address to visit patient

#1 Physician: _____ Phone: _____ Speciallty: _____

Address: _____ City/State/Zip: _____

#2 Physician: _____ Phone: _____ Speciallty: _____

Address: _____ City/State/Zip: _____

Verbal Order: _____ (date/time/source/signature)

Hospital: _____ Room #: _____ Adm: _____ D/C_____

Emergency Contact/Next of Kin: _____

P/S	Diagnosis	Code	Onset Date

Verbal Order: _____
_____

Serv.	Frequency/Duration	Physician Orders: (i.e., wound, cath, ostomy)

Pharmacy: _____ Phone: _____

Allergies: _____ Diet: _____

DME/Supplies: _____

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INTAKE/REFERRAL FORM (CONTINUED)

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Medications: (N) New (C) Change _____

Safety Measures: ☐ Cardiac Prec. ☐ Diabetic Prec. ☐ HTN Prec. ☐ O2 Prec. ☐ Standard Prec.
☐ Prevent Falls ☐ Psychiatric Prec. ☐ Maintain Safe Environment ☐ Pulm/Resp Prec.
☐ SAN Prec. ☐ Neurological Prec. ☐ Other: _____

Functional Lumitations: ☐ Amputation ☐ Paralysis ☐ Legally Blind ☐ Bowel/Bladder ☐ Endurance
☐ Dyspnea w/minor exertion ☐ Contracture ☐ Speech ☐ Hearing

Activities Permitted: ☐ Comp. Bed rest ☐ Bed rest BRP ☐ Up as Talerate ☐ Part. Wt. Bearing
☐ Independent ☐ Wheelchair ☐ Walker ☐ Cane ☐ Crutches
☐ Transfer ☐ Exercise ☐ Other: _____

Mental Status: ☐ Oriented ☐ Forgetful ☐ Disoriented ☐ Agitated ☐ Comatose
☐ Depressed ☐ Lethargic ☐ Alert ☐ Other _____

Prognosis: ☐ Poor ☐ Guarded ☐ Fair ☐ Good ☐ Excellent

Chief Complaints (Hospital/Dr. Office): _____

Hospital Stay: Significant PMH/Labs/Procedures/Results/VS Range: _____

Initial Visit: _____

Signature: _____

Title: _____ Date: _____

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