AIRMID HOME HEALTH CARE, INC.
412 West Broadway, Suite 208, Glendale, CA 91204
Tel: 818-696-2800 Fax: 818-696-2801
email: info@airmidhhc.com

REFERRAL/INTAKE INFORMATION FORM

PATIENT INFORMATION	INSURANCE INFORMATION		
Patient's Name	Admit ⌈ Reject	Admitted Date:	
Address:	Insurance:		
City: ZIP:	Medicare# Part A⌈ Part B⌈		
County:	Medicaid#		
Phone:	Social Security:		
DOB: Sex: Male⌈ Female⌈	Private Insurance:		
Race: Marital Status:	HOSPITAL INFORMATION		
PHYSICIAN INFORMATION	Hospital Admission Date:		
Physician Name:	Hospital Discharge Date		
Phone:	Surgical Procedures:		
NPI:			
Address:	DIAGNOSIS	ICD-10	Services:
City: ZIP:	Primary:		⌈SN
CARE PERSON			⌈LPN/LVN
Name:	Secondary:		⌈HHA
Relationship:			⌈PT
Phone:	3rd:		⌈OT
Address:	4th:		⌈MSW
City: ZIP:	5th:		⌈SLP
REFERRAL BY	Medications:		
⌈Physician Office			
⌈Hospital			
⌈Others	Allergies:		
Name:	Diet:		
Phone:	Equipment Needed:		
Taken By: Date:	Assigned to:		