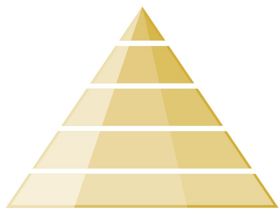

Pathways to Self-Reliance, Inc.
A CABHA Certified Agency
8025 North Point Blvd, Ste 283
Winston Salem, NC 27106
(336) 842-3396

INTAKE/REFERRAL FORM

Date of Referral: ________________ MR#: ________________________ Date: _____________________

HIC#: _________________________ Eff. Date: ______________ Referral Source: __________________

Secondary Ins.: ____ Group: __________________________

Patient: ____ Phone: _________________________

DOB: ____ Age: ______ Race: ________ Sex: ______

Address: ___________________________________ City/State/Zip: ________________________________
patient's permanent address

Address: ___________________________________ City/State/Zip: ________________________________
address to visit patient

#1 Physician: _________________________ Phone: ________________ Specialty: _________________

Address: ___________________________________ City/State/Zip: ________________________________

#2 Physician: _________________________ Phone: ________________ Specialty: _________________

Address: ___________________________________ City/State/Zip: ________________________________

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

Hospital: _____________________________ Room #: _________ Adm: __________ D/C: ___________

INTAKE/REFERRAL FORM (continued)

Emergency Contact/Next of Kin: ____

____

P/S	Diagnosis	Code	Onset Date

Surgical Procedure/Date: ____

____

Serv.	Frequency/Duration	Physician Orders: (i.e., wound, cath, ostomy)
SN		
PT		
OT		
MSS		
Aide		

Signature: ____

Title: ______________________________ Date: ______________________

INTAKE/REFERRAL FORM (continued)

Pharmacy: ______________________________ Phone: ______________

Allergies: ______________________ Diet: ________________________

DME/Supplies: ____

____

Medications: (N) New (C) Change ____________________________

____

____

____

Safety Measures: ❑ Cardiac Prec. ❑ Diabetic Prec. ❑ HTN Prec. ❑ O_2 Prec. ❑ Standard Prec. ❑ Prevent Falls ❑ Psychiatric Prec. ❑ Maintain Safe Environment ❑ Pulm/Resp Prec. ❑ SAN Prec. ❑ Neurological Prec. ❑ Other: ______________

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

Activities Permitted: ❑ Comp. Bedrest ❑ Bedrest BRP ❑ Up as Tolerated ❑ 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: ____

____

____

____