

PATIENT INTAKE		Haven Hospice		Office Phone: (562) 426-7500		Fax: (562) 427-8222																																																																									
Patient Name (Last, First, Initial)				Phone No:		MR #:																																																																									
Address				City, State		Zip																																																																									
Map Guide:		SS#:		DOB:		Age:																																																																									
P.C.G./ Contact Name				Relationship																																																																											
Address				City, State		Zip																																																																									
Home Phone:		Work Phone		Cell																																																																											
Referred by:		Date of Referral		Date Intake Completed:																																																																											
Eval assigned to:			Proj. SOC Date:			Emerg. Cat:																																																																									
Case Manager:			SOC Date			Team:																																																																									
ETHNICITY		Hispanic		SEX		Living at: HOME																																																																									
Caucasian		Afro-American		Male		RCFE																																																																									
Other				Female		SNF																																																																									
PRIMARY LANGUAGE SPOKEN		Married		HOSPITAL		Admission Date to Facility:																																																																									
		Widowed		Other		Phone# Fax#																																																																									
		Single		Patient to be transferred out of facility prior to Hospice admission																																																																											
RELIGION:		DIET		IV Access (Type):		IV Medication:																																																																									
Equipment Supplies:		Regular		Start Date:		Time:																																																																									
Walker		Wheel Chair		PUREE		Allergies: NKA																																																																									
O2 Concen.		Hospital Bed		As Tolerated																																																																											
Other		Therapeutic		HEIGHT		DME Supplier:																																																																									
				WEIGHT		Phone:																																																																									
MORTUARY		ADDRESS:				CITY, STATE																																																																									
						Phone:																																																																									
Diagnosis:				Onset Date:		ICD-9 Code:																																																																									
Diagnosis:				Onset Date:		ICD-9 Code:																																																																									
Diagnosis:				Onset Date:		ICD-9 Code:																																																																									
Diagnosis:				Onset Date:		ICD-9 Code:																																																																									
History /Pertinent Info:				Most recent hospitalization for:		Date:																																																																									
<table border="1"> <tr> <td colspan="2"></td> <td colspan="2">Physician Certifies Terminal Illness</td> <td colspan="2">Insurance Verified By:</td> <td colspan="2">Initials</td> </tr> <tr> <td colspan="2">SN Eval</td> <td colspan="2">MSW</td> <td colspan="2">Specific Procedures/Treatment:</td> <td colspan="2">Date</td> </tr> <tr> <td colspan="2">CHHA</td> <td colspan="2">Chaplain</td> <td colspan="2"></td> <td colspan="2"></td> </tr> <tr> <td colspan="2"></td> <td colspan="2"></td> <td colspan="2"></td> <td colspan="2"></td> </tr> <tr> <td colspan="4">Hospice Admit to:</td> <td colspan="2"></td> <td colspan="2"></td> </tr> <tr> <td colspan="2">Routine</td> <td colspan="2">General Inpatient</td> <td colspan="2"></td> <td colspan="2"></td> </tr> <tr> <td colspan="2">Continuous Care</td> <td colspan="2"></td> <td colspan="2"></td> <td colspan="2"></td> </tr> <tr> <td colspan="4">Start time:</td> <td colspan="2"></td> <td colspan="2"></td> </tr> <tr> <td colspan="2">AM</td> <td colspan="2">PM</td> <td colspan="2"></td> <td colspan="2"></td> </tr> </table>										Physician Certifies Terminal Illness		Insurance Verified By:		Initials		SN Eval		MSW		Specific Procedures/Treatment:		Date		CHHA		Chaplain														Hospice Admit to:								Routine		General Inpatient						Continuous Care								Start time:								AM		PM					
		Physician Certifies Terminal Illness		Insurance Verified By:		Initials																																																																									
SN Eval		MSW		Specific Procedures/Treatment:		Date																																																																									
CHHA		Chaplain																																																																													
Hospice Admit to:																																																																															
Routine		General Inpatient																																																																													
Continuous Care																																																																															
Start time:																																																																															
AM		PM																																																																													
Primary Payer Name:				Primary Payer No.																																																																											
Phone #:				Auth#:		Case Manager:																																																																									
Secondary Payer Name:				Secondary Payer No.																																																																											
Phone #:				Auth#:		Case Manager:																																																																									
Primary M.D. (First & Last Name)				Secondary M.D.																																																																											
Address:				Address																																																																											
City, State				ZIP		City, State																																																																									
UPIN #:		Phone#		UPIN #:		Phone#																																																																									
LIC.#		Fax#		LIC#		Fax#																																																																									
Intake Completed by:				RN/LVN Signature		Date:																																																																									
						Time																																																																									