Arkansas Medical Supply

# INTAKE FORM

Date: _____

## Information about Person Making Referral

First Name: _____ Last Name: _____
Company: _____
Telephone: _____

## Information about Client

First Name: _____ M.I._____ Last Name:_____
Street Address: _____
City/State/Zip: _____
Telephone: _____ Date of Birth (mm/dd/yyyy): _____
Emergency Contact: _____ Relationship: _____
Emergency Contact Telephone: _____

## Information about Ordering Physician and/or Primary Care Physician

Name: _____ Address: _____
City/State/Zip: _____
Telephone: _____ Specialty: _____

## Supplies Needed by the Client

Urological
Catheter size: FR.: - SELECT - Coude: ☐ Y ☐ N
How often? ____
Incontinence
Item: (please check) ☐ Diapers ☐ Pull-ups ☐ Chux/Underpads
Size: - SELECT - Client's weight: _____ lbs.
Latex allergy: ☐ Y ☐ N
Has the client ever received the same or similar supplies? ☐ Y ☐ N
If yes, please list supplies: _____
Name of previous supplier: _____ City: _____
Date of last order (mm/dd/yyyy): _____
Is the item being replaced? ☐ Y ☐ N
Describe condition for need: _____

## Client's Insurance Information

Is the client enrolled in a Medicare, Medicaid, HMO/PPO or private insurance program? ☐ Y ☐ N
Primary Insurance: _____ Telephone: _____
Secondary Insurance: _____ Telephone: _____