INTAKE FORM

Consano Health

Ph:(214)233-6139 Fax:(214)550-2652
referralstx@consano.health

FAX _____ REPRESENTATIVE_____ DATE _____

PATIENT INFORMATION

Patient Name	Male Female	Phone	Date of Birth
Scheduling contact if other than pt		Relationship to Patient	Phone
Address	City	State	Zip	Rm#orGateCode
Is patient currently in an assisted living facility? Yes No If YES, name of ALF			
POA		Phone	
BillingAddress:	City	State	Zip	Rm#orGateCode
Notes:			

INSURANCE INFORMATION **Please include copy of insurance card/s**

Primary Insurance	MemberID	Phone
Secondary Insurance	MemberID	Phone

REFERRAL SOURCE

Source	Point of Contact	Phone
Name		
If no current home health, is there a preferred HH? Yes No Name	Phone	Order Fax
CaseNurse		Order Fax

Email	Phone	DON	Phone

OTHER PARTICIPATING CARE PARTNERS

Primary Care Physician Requesting Clinical Notes YES NO	Phone Fax	Point of Contact
	Discharge Coordinator	

Skilled Nursing	Phone		

SUSPECTED WOUND ETIOLOGY (IF AVAILABLE)

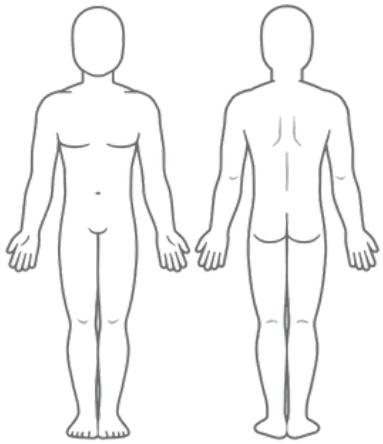
Check as many as you may suspect apply

Venous stasis Post thrombotic Diabetic Ulcer Burn
Non-healing traumatic (e.g. resulting from a fall)
Post surgical (include procedure if known) Pressure injury
Has this wound been treated by healthcare professionals? Yes No
If so, for what period of time? <30 days 30-90 days >90 days

OTHER RELEVANT CONDITIONS

Check as many as you may suspect apply

Diabetes Hypertension Venous Insufficiency Malnutrition
Moderate to severe mobility restriction Edema (including lymphedema)
Arterial Insufficiency Suspected infection at the wound site



EXAMPLE: Place "X" over area of wound