

Non-Urgent/Scheduled Admission Intake Form



7596422

1. Last Name <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>										Medical Record Number <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>										FC <input type="text"/>		Date of Birth <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>																											
Initial Assessment/Request Date <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>										Attending <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>										Service <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>										DRG# <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>										ICD 9# <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>									
Anticipated Admit Date <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>										UR Nurse <input type="text"/> <input type="text"/>										Diagnosis: <input type="text"/>																													
2. Source of Request <input type="checkbox"/> Ancillary <input type="checkbox"/> Clinic HB <input type="checkbox"/> Clinic PCN <input type="checkbox"/> MD <input type="checkbox"/> Nsg Unit <input type="checkbox"/> Other: _____										3. Review Request Type <input type="checkbox"/> On-line HAR <input type="checkbox"/> Phone Request <input type="checkbox"/> Fax Questionnaire <input type="checkbox"/> In-person Request <input type="checkbox"/> Other: _____										5. HAR Status Within HAR guidelines? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown										5. Scheduled Procedure? <input type="radio"/> Yes <input type="radio"/> No Date of Procedure or OR: <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> Pre-Op Clinic Visit <input type="radio"/> Yes <input type="radio"/> No Date of Pre-Op Clinic Appt. <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>																			
6. Pre Admit Assessment Review Assessment Source: (May choose more than one) <input type="checkbox"/> Spoke with patient/family/caregiver <input type="checkbox"/> MR/clinical info review <input type="checkbox"/> MD/Clinic consult <input type="checkbox"/> Fax Questionnaire <input type="checkbox"/> Other: _____										7. LOC Ordered As <input type="checkbox"/> OP/AST <input type="checkbox"/> Admit <input type="checkbox"/> OBV <input type="checkbox"/> Placement Appropriate LOC <input type="checkbox"/> OP/AST <input type="checkbox"/> Acute <input type="checkbox"/> OBV <input type="checkbox"/> LLOC										8. Account Type Requested <input type="checkbox"/> 10 <input type="checkbox"/> 50 <input type="checkbox"/> 20 <input type="checkbox"/> Other Appropriate Account Type <input type="checkbox"/> 10 <input type="checkbox"/> 50 <input type="checkbox"/> 20 <input type="checkbox"/> Other																													
9. Preliminary DCP Action/Intervention (May choose more than one) <input type="checkbox"/> Coordination of O/P Care <input type="checkbox"/> DPAHC <input type="checkbox"/> Funding/Benefits <input type="checkbox"/> Preliminary Referrals to: <input type="checkbox"/> B&C <input type="checkbox"/> DME <input type="checkbox"/> EW <input type="checkbox"/> HH <input type="checkbox"/> Psych <input type="checkbox"/> SNF <input type="checkbox"/> Other: _____										<input type="checkbox"/> Patient Education/Information <input type="checkbox"/> Transportation <input type="checkbox"/> None <input type="checkbox"/> Other: _____										10. Continuing Care/Anticipated Discharge Needs (May choose more than one) <input type="checkbox"/> Acute Tx <input type="checkbox"/> Funding/Benefits <input type="checkbox"/> Alternate Housing <input type="checkbox"/> Home Health <input type="checkbox"/> APS/Social <input type="checkbox"/> O/P follow up <input type="checkbox"/> Caregiver <input type="checkbox"/> Other: _____ <input type="checkbox"/> DME																													
11. MOD Referral Yes <input type="checkbox"/> MOD# <input type="text"/> <input type="text"/>										12. DCP MR Assessment Note Yes <input type="checkbox"/> No <input type="checkbox"/> (If no comment required)																																							
13. Assessment Outcome (Choose only one) <input type="checkbox"/> Admission Deferred <input type="checkbox"/> Admission Cancelled <input type="checkbox"/> Admission Status Change <input type="checkbox"/> Admission Approved <input type="checkbox"/> Insufficient Info Available										14. Comments <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>																																							
15. Assessment Completion Date <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>										16. Reviewer # <input type="text"/> <input type="text"/>										Date Reviewed <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>																													
Admission Intake 21804										Clerical Date Received <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>										Initials <input type="text"/> <input type="text"/>																													

Source of both charts: University of California Health System, Davis.