EAST TENNESSEE Children's Hospital

Home Health Care Intake Data

Name: _____

Repeat admission: Y N

D.O.B.:_____

Age: _____ M F

Race: Caucasian, Non-Caucasian, Hispanic

Address: _____

_____

County: _____

Pt's SS#: _____

Phone #: _____

Height: _____ Weight:_____

Allergies: _____

Father's name: _____

Father's SS #: _____

Father's D.O.B. _____

Father's address if diff: _____

_____

Father's employer:_____

Employer's phone #: _____

Mother's name: _____

Mother's SS#: _____

Mother's D.O.B.: _____

Mother's address if diff: _____

_____

Mother's employer: _____

Employer's Phone #: _____

Emergency contact name:_____

Address: _____

Phone #: _____

Relationship to patient: _____

Referring M.D.: _____

M.D. phone #: _____

Ordered services: _____

_____

_____

_____

Insurance Private/Tenncare

Company/MCO: _____

Claims address: _____

_____

Claims phone #:_____

Effective date: _____

Policy holder: _____

Group #:_____

ID #: _____

Secondary Ins.: _____

Secondary Ins.: _____

Claims address: _____

_____

Policy holder: _____

ID #: _____

Group #: _____

Oasis Eligible 18 yr or ⬆ Y N

Diagnosis: _____

Directions: _____

_____

_____

_____

_____

S.O.C. Date:_____

Signature:_____

Date: _____

White-Chart Yellow-Pre-Cert Pink-Clinical Coor