NURSES FOR SAFE ACCESS
A COLLECTIVE OF CARING NURSES

BENEFICIARY/MEMBER MEDICAL **INTAKE FORM**

1. BENEFICIARY/MEMBER INFORMATION

Name:_____ DOB:_____ M◯ F◯

Address:_____Phone #:_____

City:_____State:_____Zip Code:_____Cell#:_____

Insured By:_____Nurse Advocate:_____

Insured ID #:_____Insured Group #_____

Email address:_____Primary Language: _____

2. NURSE-ADVOCATE INFORMATION

Name:_____Specialty:_____

Address:_____Phone #:_____

City:_____State:_____Zip Code:_____Cell #_____

Nursing License #:_____License Expiration Date: _____

Start of Care:_____

Email address:_____

3. PRIMARY CARE PHYSICIANS

Name:_____

Address:_____Phone #:_____

City:_____State:_____Zip Code:_____ Fax #:_____

Email address:_____

Name:_____

Address:_____Phone #:_____

City:_____State:_____Zip Code:_____ Fax #:_____

Email address:_____

Name:_____

Address:_____Phone #:_____

City:_____State:_____Zip Code:_____ Fax #:_____

Email address:_____

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Member's Name:_____

4. MEDICAL INFORMATION – Include ICD-10 codes where appropriate.

_____ _____ Date of onset: _____
Primary Diagnosis ICD-10 code

_____ _____ Date of onset: _____
Secondary Diagnosis ICD-10 code

_____ _____ Date of onset: _____
Secondary Diagnosis ICD-10 code

_____ _____ Date of onset: _____
Secondary Diagnosis ICD-10 code

_____ _____ Date of onset: _____
Secondary Diagnosis ICD-10 code

_____ _____ Date of onset: _____
Secondary Diagnosis ICD-10 code

_____ _____ Date of onset: _____
Secondary Diagnosis ICD-10 code

5. FAMILY AND COMMUNITY BASED SERVICES-Please check all that apply.

1. Family close by to help with health care: Yes ◯ No ◯
2. Friends close by to help with health care: Yes ◯ No ◯
3. Support Groups: Church ◯ AA ◯ Other meetings: ◯ _____
4. Other Clubs: ◯ _____
   _____

6. LEVEL OF CARE AND SUPPORT Please check only those that apply.

1. ◯ Home alone with family member who can help.
2. ◯ Home alone providing care for family member.
3. ◯ Living with relative.
4. ◯ Living with friend.
5. ◯ Living in skilled nursing facility.
6. ◯ Living with Hospice services.
7. ◯ Concerned about loved ones during hospitalization.
8. ◯ Concerned about pet care during hospitalization.
9. ◯ Living at Home Alone without help

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7. SKILLED SERVICES PROVIDED OR NEEDED

Not Applicable: ◯

PT _____

Speech _____

OT_____

Dietician _____

Other _____

8. MEDICATION/ PRESCRIPTION DRUGS

ALLERGY: _____ **KNOWN REACTION:**_____

ALLERGY: _____ **KNOWN REACTION:**_____

ALLERGY: _____ **KNOWN REACTION:**_____

ALLERGY: _____ **KNOWN REACTION:**_____

MEDICATIONS:

Name: _____ **Dose:** _____ **Frequency:** _____

Name: _____ **Dose:** _____ **Frequency:** _____

Name: _____ **Dose:** _____ **Frequency:** _____

Name: _____ **Dose:** _____ **Frequency:** _____

Name: _____ **Dose:** _____ **Frequency:** _____

Name: _____ **Dose:** _____ **Frequency:** _____

Name: _____ **Dose:** _____ **Frequency:** _____

Name: _____ **Dose:** _____ **Frequency:** _____

Name: _____ **Dose:** _____ **Frequency:** _____

9. VITAMINS & SUPPLEMENTS

1._____**2**_____

3._____**4.**_____

5._____**6.**_____

7._____**8.**_____

9._____**10.**_____

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10. MEDICAL CANNABIS HISTORY

- ◯ No History
- ◯ Long Time History
- ◯ Minimal History
- ◯ Recent Cannabis History

Type/Name of Product_____

Type of Delivery: ◯ Smoked ◯ Vaped ◯ Edibles ◯ Sublingual ◯ Capsules ◯ Suppositories ◯ Topical

USAGE: Product/Delivery (example: AC/DC, vaped)_____

Frequency: ◯ 1 X DAY ◯ 2 X DAY ◯ 2-3 X DAY ◯ 3 X DAY ◯ 4 X DAY ◯ AS NEEDED FOR COMFORT

OUTCOMES: ◯ Over medicated (Couch locked) ◯ Hallucinations ◯ Sleep Aid ◯ Pain relief ◯ Increased Appetite ◯ Decreased Appetite ◯ Relieved Nausea ◯ Elevates Mood ◯ Enhances Creativity ◯ Elevates feeling of overall wellness Other: _____

_____

Type /Name of Product_____

Type of Delivery: ◯ Smoked ◯ Vaped ◯ Edibles ◯ Sublingual ◯ Capsules ◯ Suppositories ◯ Topical

USAGE: Product/Delivery (example: AC/DC, vaped)_____

Frequency: ◯ 1 X DAY ◯ 2 X DAY ◯ 3 X DAY ◯ 4 X DAY ◯ 5 X DAY ◯ AS NEEDED FOR COMFORT

OUTCOMES: ◯ Sleep Aid ◯ Pain relief ◯ Increased Appetite ◯ Decreased Appetite ◯ Relieved Nausea ◯ Elevates Mood ◯ Enhances Creativity ◯ Elevates feeling of overall wellness ◯ Over medicated (Couch locked) ◯ Hallucinations Other: _____

Type /Name of Product_____

Type of Delivery: ◯ Smoked ◯ Vaped ◯ Edibles ◯ Sublingual ◯ Capsules ◯ Suppositories ◯ Topical

USAGE: Product/Delivery (example: AC/DC, vaped)_____

Frequency: ◯ 1 X DAY ◯ 2 X DAY ◯ 3 X DAY ◯ 4 X DAY ◯ 5 X DAY ◯ AS NEEDED FOR COMFORT

OUTCOMES: ◯ Sleep Aid ◯ Pain relief ◯ Increased Appetite ◯ Decreased Appetite ◯ Relieved Nausea ◯ Elevates Mood ◯ Enhances Creativity ◯ Elevates feeling of overall wellness ◯ Over medicated (Couch locked) ◯ Hallucinations Other: _____

Member's Name:_____

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11. NUTRITIONAL REQUIREMENTS AND ALCOHOL CONSUMPTION

Please include type of diet, method of feeding, amount and frequency. (Example: Vegan/ Wine 1 X day)

_____
_____
_____
_____
_____

12. NURSE ADVOCATION CARE PLAN

SHORT HISTORY:

_____
_____
_____
_____
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_____
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NOTES:

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13. FUNCTIONAL LIMITATIONS

◯ NO LIMITATIONS NOTED

MOTOR: May include limitations with walking and/or gross motor movement.

Notes:_____
_____
_____
_____
_____
_____

SELF HELP: May include limitations with activities of daily living such as bathing, toileting, eating, and dressing.

Notes:_____
_____
_____
_____
_____
_____

COMMUNICATIONS/SENSORY: May include limitations with hearing, speech, and sight.

Notes:_____
_____
_____
_____
_____
_____

14. ACTIVITIES AND EXERCISE

◯ NO LIMITATIONS NOTED

Notes:_____
_____
_____
_____
_____
_____
_____

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15. MENTAL STATUS

◯ NOT APPLICABLE

May include information related to behavior and /or cognition such as aggression, depression, agitation, confusion, and developmental disabilities.

Notes:_____

16. DURABLE MEDICAL EQUIPMENT

◯ NOT APPLICABLE

TYPE	PROVIDER NAME	FUNDING SOURCE

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Member's Name:_____

17. MEDICAL SUPPLIES

○ NOT APPLICABLE

TYPE	PROVIDER NAME	FUNDING SOURCE

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Member's Name:_____

18. THERAPIES/REFERRALS

◯ NOT APPLICABLE

Check all that apply and please include date the referral was made and why. If therapy is ongoing, please indicate the current progresss/status in Section 21.

Physical Therapy Date:_____ Referral Reason:_____

Occupational Therapy Date: _____Referral Reason:_____

Speech Therapy Date: _____ Referral Reason: _____

Enterostomal Therapy Date: _____ Referral Reason: _____

Medical Social Worker Date:_____ Referral Reason_: _____

Nutritionist Date: _____ Referral Reason: _____

Other/List:_____Date: _____ Referral Reason: _____

Other/List:_____Date: _____ Referral Reason: _____

Other/List:_____Date: _____ Referral Reason: _____

Other/List:_____Date: _____ Referral Reason: _____

Other/List:_____Date: _____ Referral Reason: _____

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19. TREATMENT GOALS/DISCHARGE PLAN

Please check only one.

Upon completion of treatment plan, the beneficiary will be able to function independently and maintain self safely in the home setting.

Upon completion of this treatment plan, the beneficiary will continue to need:

- ◯ Minimal support to be maintained safely in the home setting.
- ◯ Moderate support to be maintained safely in the home setting.
- ◯ Maximum support to be maintained safely in the home setting.

Notes:_____
_____
_____
_____
_____
_____
_____
_____
_____

20. TRAINING NEEDS FOR BENEFICIARY/FAMILY

- ◯ No training needs have been identified for the beneficiary and/or the family during this treatment period.
- ◯ Yes, there are training needs for the beneficiary and/or family during the treatment period.

If yes box is checked, please describe the training needs and name of the provider.

Notes:_____
_____
_____
_____
_____
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_____

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Member's Name:_____

21. SUMMARY OF BENEFICIARY STATUS DURING THIS TREATMENT PERIOD

Please include all data relevant to beneficiary's care.

Notes:_____

22. SIGNATURES REQUIRED

After completing all sections, please obtain signatures from patient and nurse advocate below:

Patient _____ **Date:** _____

Nurse Advocate _____ **Date:** _____

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24. EXTRA PAGE FOR NOTE TAKING

Please include all data relevant to beneficiary's care.

Notes:_____

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Member's Name:_____

24. EXTRA PAGE FOR NOTE TAKING

Please include all data relevant to beneficiary's care.

Notes:_____