INTAKE FORM

ATHENA SPECIALTY GROUP

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❑ UPDATED INTAKE (only complete patient name & updated information) ❑ 30 DAY REVERIFICATION (Name & DOB only)

FAX _____ REPRESENTATIVE_____ DATE _____

PATIENT INFORMATION				
Patient Name	❑ Male ❑ Female	Phone	Date of Birth	
Scheduling contact if other than patient		Relationship to patient	Phone	
Address	City	State	Zip	Rm # or Gate Code
Is patient currently in an assisted living facility? ❑ Yes ❑ No If YES, name of ALF		Name of ALF Care Coordinator		
POA		Phone		
Billing Address	City	State	Zip	Rm # or Gate Code
Notes:				

INSURANCE INFORMATION **Please include copy of insurance card/s**		
Primary Insurance	Member ID	Phone
Secondary Insurance	Member ID	Phone

REFERRAL SOURCE		
Source	Point of Contact	Phone

HOME HEALTH PARTNER			
Name	Phone	Order Fax	
If no current HH, is there a preferred HH? ❑ Yes ❑ No Name	Phone	Order Fax	
Case Nurse	Phone	DON	Phone

OTHER PARTICIPATING CARE PARTNERS			
Primary Care Physician	Phone	Point of Contact	
Requesting Clinical Notes? ❑ Yes ❑ No	Fax		
Skilled Nursing	Phone	Discharge Coordinator	Phone

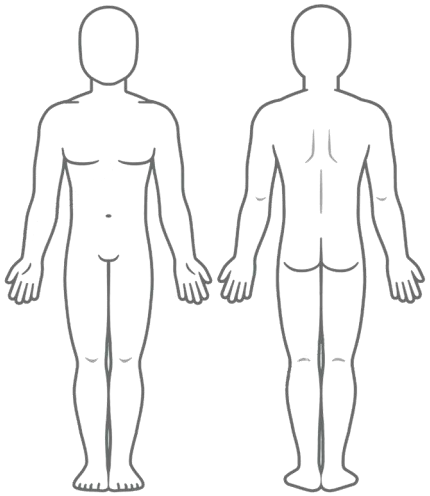
SUSPECTED WOUND ETIOLOGY (IF AVAILABLE)
Check as many as you may suspect apply

❑ 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



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