



Mission Intake Form

Rev 11/11

Initials of Intake Person _____ Date & Time _____

Caller & Phone #: _____

Heard about AF? _____ Gender _____ Race _____ Weight _____ Date of Birth _____ Age _____

Patient Name _____ Insurance: Medicare _____ Medicaid _____ Private: _____

Employer _____ Combined Household Income _____

Patient Address _____

City _____ State _____ County _____ Zip _____

Home # _____ Wk # _____ Cell # _____

Email Address: _____

Illness _____

Crutches _____ Oxygen _____ Other _____ Wheelchairs **must be shipped** Transplant Y / N Hours _____

Reason for Visit _____

Origination Airport _____ Destination Airport _____

Appointment Date _____ Time _____ How Long at Appt. _____

Departure Date & Time _____ Return Date & Time _____

Ground transportation @ destination & phone # _____

Lodging @ destination & phone # _____

1st Passenger Name _____ Relationship to Patient _____

Weight _____ Age _____ Date of Birth _____

2nd Passenger Name _____ Relationship to Patient _____

Weight _____ Age _____ Date of Birth _____

Baggage Weight _____ (in soft bag, 5 lb per person per day) **Total Posted Weight** _____

Doctor You Have Seen _____ Attn: _____

Facility Name _____

Address: _____ City, State & Zip: _____

Phone # _____ FAX# _____

Doctor at Destination _____ Attn: _____

Facility Name _____

Address _____ City, State & Zip: _____

Phone#: _____ FAX # _____