



Mission Intake Form

Rev 1/11

Initials of Intake Person _____ Date & Time _____

Caller & Phone #: _____

Heard about AF? _____ Insurance: Medicare ___ Medicaid ___ Private: _____

Patient Name _____

Gender ___ Race ___ Date of Birth _____ Age ___ Weight _____ Employer _____

Patient Address _____

City _____ State _____ County _____ Zip _____

Home # _____ Wk # _____ Cell # _____

Email Address: _____

Medical Condition _____

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

Purpose _____

Origination _____ Destination _____

Appointment Date _____ Time _____ How Long of 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-sided bag, 5 lb per person per day) Total Posted Weight _____

Referring Dr. _____ Attn: _____

Facility Name _____

Address: _____ City, State & Zip: _____

Phone # _____ FAX# _____

Doctor at Destination _____ Attn: _____

Facility Name _____

Address _____ City, State & Zip: _____

Phone#: _____ FAX # _____