Mission Intake Form

Rev 6/17

Initials of Intake Person _______ Date & Time _______

Caller & Phone #:____

Who referred you? ________________ Gender____ Race____ Weight____ Height____ Date of Birth_________ Age___

Patient Name______________________________ Insurance: Medicare__ Medicaid__ Private __ None __ Unknown __

Employer____ Combined Household Income________________

Patient Address____

City ______________________________ State__________ County____________________________ Zip___________

Active Military or Veteran: Daughter ( ) Grandchild ( ) Grandparent( ) Parent ( ) Patient ( ) Sibling ( ) Son ( ) N/A ( )

Number in Household_____________

Phone 1 #_______________________ Phone 2. #_____________________ Phone 3 # _________________________

Email Address:____

Medical afflicition:____

Crutches ___ Oxygen ___Other_____________ Wheelchairs **must be shipped** Transplant Y / N # of Hours ________

Reason for Visit ____

Origination City & ST _______________________________ Destination City & ST _____________________________

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 ___________________

Passenger 1: phone _________________Gender___ Race___ Weight____ Height____ Date of Birth_________ Age___

1st Passenger Address____ Military/Veteran_________________

City ______________________________ State__________ County____________________________ Zip___________

2nd Passenger Name ____ Relationship to Patient ____________________

Passenger 2: phone _________________ Gender___ Race___ Weight____ Height____ Date of Birth_________ Age___

2nd Passenger Address____ Military/Veteran_________________

City ______________________________ State__________ County____________________________ Zip___________

Baggage Weight ________________ (in soft bag) Total Posted Weight _____________________

Doctor You Have Seen Recently ____________________________________ Attn: _____________________________

Facility Name ________________________________ Address: ____

City, State & Zip: ____Phone # ___________________________________

FAX# ____ E-Mail:____

Doctor at Destination _______________________________________ Attn: ______________________________________

Facility Name ________________________________ Address: ____

City, State & Zip: ____Phone # ___________________________________

FAX# ____ E-Mail:____