Mission Intake Form

Rev 7/10

Initials of Intake Person _______ Date & Time _______

Caller & Phone #:____

Hear 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 # ___________________________