Mission Intake Form

Rev 08/14

Initials of Intake Person_____Date & Time _____

Caller & Phone #:_____

Heard about AF?_____Gender_____Race_____Weight____ Height ___Date of Birth_____Age___

Patient Name_____Insurance: Medicare____Medicaid_____Private: _____

Employer_____Combined Household Income_____

Patient Address_____ Number in Household _____

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 _____Destination _____

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 _____

Phone_____ Weight_____Height _____Age_____Date of Birth _____

2nd Passenger Name_____Relationship to Patient _____

Phone_____ Weight_____Height _____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 # _____

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