OPTIMISTIC HEALTHCARE SOLUTION
PATIENT INTAKE FORM

Referral Source: _____

Documented input from referral sources regarding the quality of operations and services.

Is our staff helpful and courteous?	❑ YES	❑ NO
Are the quality, variety, and availability of products we carry adequate for your patient needs?	❑ YES	❑ NO
Are you satisfied with the ease of calling in a referral?	❑ YES	❑ NO
Comments:		

Patient Information

Last Name Hofstede Full First Name Kimberly

Address 123 Main St

City The Woodlands State TX Zip 77380

Phone: 2812986742

Gender: ❑ Male ❑ Female Date of Birth: 1966-08-06 SSN: 123-45-6789

Ordering/Prescriber Dr. Sarah Lee NPI # 1234567890

Address 200 Wellness Blvd Houston TX 77002 Phone # 7135559876

Related Diagnoses for Service(s) Provided

J44.9, G47.33

Patient Height: _____ Patient: Weight: _____

Emergency Contact John Hofstede Phone # 2815551122

Insurance Coverage

#1 _____ Policy # PM12345678

Address _____ Phone # _____

Name of Insured: Kimberly Hofstede Date of Birth: _____

#2 _____ Policy # _____

Address _____ Phone # _____

Name of Insured: _____ Date of Birth: _____

Service Begin Date 2025-10-01

Patient Currently Hospitalized? ❑ Yes ❑ No If Yes, Name of Hospital _____

Phone #: _____ Room # _____ Discharge Date _____

Name(s) of other home health care providers visiting patient: _____

Equipment / Services Needed:

Oxygen concentrator; Nebulizer tubing

Person Taking Referral: _____ Date received: CASE-2025-00123

Patient Contacted: Date: _____ Time: _____ Expected Delivery Date: _____ Time: _____

Form Revised: 08/01/2023

Optimistic HealthCare Solutions

INITIAL EQUIPMENT MANAGEMENT ADMISSION ASSESSMENT AND PLAN OF SERVICE

PATIENT Kimberly Hofstede DATE OF BIRTH 1966-08-06 ADMISSION DATE 2024-05-15

PATIENT'S PHONE NUMBER 2812986742

EQUIPMENT ORDERED (include settings, if applicable) (document any adjustments to equipment)

Oxygen concentrator; Nebulizer tubing - E1390, A7003

OTHER INDIVIDUALS/ORGANIZATIONS INVOLVED IN PATIENT'S CARE:

❑ CHECK IF EQUIPMENT / SUPPLIES ARE PICKED UP AT PHARMACY (IF PICKED UP AT THE PHARMACY THE HOME ASSESSMENT IS NOT PERFORMED, HOWEVER SAFETY INFORMATION IS DISCUSSED WITH THE PATIENT / CAREGIVER)

HOME ASSESSMENT-ENVIRONMENTAL / SAFETY

ARCHITECTURAL BARRIERS ☐ ADEQUATE ☐ INADEQUATE
SHELTER, HEAT, WATER, PLUMBING, REFRIGERATION, COOKING ☐ ADEQUATE ☐ INADEQUATE
ELECTRICAL (check ground, no use of extension cords) ☐ ADEQUATE ☐ INADEQUATE
FIRE SAFETY (has smoke detector/alarm and extinguisher) ☐ ADEQUATE ☐ INADEQUATE
DOES ANYONE SMOKE IN THE HOME?
DOCUMENT ANY OTHER SAFETY OR HEALTH HAZARDS CONCERNS AND INFORMATION GIVEN THE PATIENT:

PLAN OF SERVICE

Identified Needs/Problems:

- The patient is or may be unfamiliar with the use and maintenance of the DMEPOS dispensed.
- The patient may be uncertain of home safety.
- The patient may be required to troubleshoot the equipment or use back-up equipment.
- The patient may require follow-up services.

Expected Outcomes:

- The patient will be provided prescribed equipment to comply with the prescription.
- The patient will use the DMEPOS as prescribed.
- The patient will use and maintain DMEPOS in a safe/proper manner.
- The patient will adhere to home safety guidelines.
- The patient will be able to troubleshoot any equipment problems and/or use a back-up system.
- The patient will know how to obtain follow-up services as needed.

Services/Actions Provided:

- Deliver and set up DMEPOS at a mutually agreed upon time and place.
- Provide adjustments to equipment, as applicable.
- Recommend any additional evaluations of the prescribed equipment, items and/r services.
- Communicate any risk, precautions, repairs, replacement, etc. to the patient/caregiver and/or to the prescriber, as applicable
- Provide training in safe/proper use, cleaning, and maintenance of equipment.
- Provide infection control instruction.
- Provide training and written, or website information for patient rights and responsibilities, supplier standards, home safety, HIPAA Notice of Privacy Practices, emergency planning, scope of service / marketing info, warranty cards (if applicable) and provide financial responsibilities.
- Demonstrate troubleshooting of equipment and correct use of back-up system (if provided).
- Provide written instructions for obtaining routine/emergency follow-up services
- Provide warranty information for equipment and items provided. Inform patient of the actions that may void a warranty.
- Develop home visit schedule to preform equipment preventative maintenance and service, as applicable,
- Coordinate with other health care providers, as appropriate.

I acknowledge training in the use of equipment and products provided and the performance of the Equipment Management Admission Assessment and Plan of service on the date noted.

Patient Signature Date Staff Member

Form Revised: 08/01/2023