



# JSSA HOSPICE Intake Worksheet

Date \_\_\_\_\_

## Patient Demographics

Last Name \_\_\_\_\_

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

DOB \_\_\_\_\_

SS# \_\_\_\_\_

Is the patient at home?  Y  N Is the patient in a facility?  Y  N If yes, skilled?  Y  N

Medicare number \_\_\_\_\_ Medicaid number \_\_\_\_\_

Private or secondary \_\_\_\_\_ ID# \_\_\_\_\_

Gender:  Male  Female

Marital Status:  Single  Married  Divorced  Widowed  Other

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

## Referral

Name \_\_\_\_\_

Organization \_\_\_\_\_ Contact # \_\_\_\_\_

Expected SOC \_\_\_\_\_

Holocaust Survivor  YES  NO

Previous Hospice admissions  YES  NO

Hospice Organization \_\_\_\_\_

How did you hear about JSSA Hospice \_\_\_\_\_

## Family info

Primary Contact \_\_\_\_\_

Phone # \_\_\_\_\_

Relationship with Patient \_\_\_\_\_

POA  Yes  No

**Physician Information**

Attending Physician \_\_\_\_\_

Office Phone \_\_\_\_\_ Fax \_\_\_\_\_

Hospice Dx \_\_\_\_\_

Course of present illness: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Hospitalization – Name of Hospital \_\_\_\_\_

Dates \_\_\_\_\_