☐ Telephone

☐ Personal Visit

# INQUIRY RECORD

Date _____

Patient Name _____ Age _____ M ☐ F ☐ Birthdate _____

**General Information**

Patient Address _____

Spouse Name _____ Age Spouse _____

Name of Inquirer _____ Phone # _____

Responsible Party _____ Rel to Pt _____ Phone # _____

Reference source _____

Patient Current Location _____ Hospital Dates _____ through _____

Prior SNF stays (60) days _____

_____

Attending Pnysician to follow Yes ☐ No ☐ Phone # _____

New Physician _____ Phone # _____

Confirmed By _____

**Medical Information**

Primary Diagnosis (Date of Onset) _____

Secondary Dx _____ Surgery (Date) _____

Specialized Drug/Treatment Regimen _____

_____

_____

| | | | |
|---|---|---|---|
| ☐ Alert | ☐ Walk/Assist | ☐ Continent | ☐ Weight |
| ☐ Confused | ☐ Chair Only | ☐ Incontinent | ☐ Feed Self |
| ☐ Non Communicative | ☐ Bedridden | ☐ Cath | ☐ Assist Feed |
| ☐ Comatose | ☐ Decubitus | ☐ Colostomy | ☐ Special Diet |
| ☐ Ambulatory | ☐ Wounds | ☐ Oxygen | ☐ Tube Fed |
| | | ☐ Continuous ☐ PRN | ☐ IV's |

Additional Information _____

_____

_____

**Billing Information Rehab Needs**

Physical Therapy _____ Occupational Therapy _____

Speech Therapy _____ Other _____

Re-admit Yes ☐ No ☐ A/P Balance _____

Medicare # _____ Part A _____ Part B _____

VA _____ Champus/HMO _____

**Follow-up**

Admit Date _____ Room Type _____ Rate _____ Deposit _____

Arriving by Car ☐ Ambulance ☐

Arrangement to Sign Agreements _____

Follow-up Dates _____ Results _____

_____ Results _____

Completed By: _____

SNF-1114

## FIXED INCOME

| | Income | |
|---|---|---|
| | Monthly | Annual |
| Social Security (name of person to whom check is issued) | $ | $ |
| Pension (source) _____ | $ | $ |
| Insurance and/or annuities | $ | $ |
| Other (describe) _____ | $ | $ |
| _____ | | |

## INVESTMENTS

| | Principal | | Income | |
|---|---|---|---|---|
| | Cost | Market Value | Monthly | Annual |
| Securities (attach list) | $ | $ | $ | $ |
| Real Estate | $ | $ | $ | $ |
| Savings accounts, certificates | $ | $ | $ | $ |
| Trust funds | $ | $ | $ | $ |
| Other (Please describe below | $ | $ | $ | $ |
| | _____ | _____ | _____ | _____ |
| Total | $ | $ | $ | $ |

Please describe location of above assets:

_____

_____

If assets are listed in the "Other" category above, please describe the nature of such assets.

_____

_____

_____

## LIABILITIES

Please describe below all financial liabilities, including, for example, home mortgages, automobile loans, unpaid m cal bills not covered by insurance and credit card balances:

_____

_____

_____

_____

I affirm that the foregoing is a true statement of facts known by me, and that it is submitted as part of an application residency at the Facility.

Date _____ Signature _____