FREEDOM BED – PATIENT INTAKE FORM

DATE: _____

REFERRAL'S NAME: _____

TITLE: _____

COMPANY NAME: _____

ADDRESS 1: _____

ADDRESS-2: _____

CITY: _____ STATE: _____

COUNTRY: _____ POSTAL CODE: _____

PHONE: _____ FAX: _____

EMAIL: _____ WEBSITE: _____

PHYSICIAN / CASE MANAGER's NAME: _____

TITLE: _____

COMPANY NAME: _____

ADDRESS 1: _____

ADDRESS-2: _____

CITY: _____ STATE: _____

COUNTRY: _____ POSTAL CODE: _____

PHONE: _____ FAX: _____

EMAIL: _____ WEBSITE: _____

CLIENT/PATIENT NAME: _____

DATE OF BIRTH: _____ *SSN:* _____

ADDRESS-1: _____

ADDRESS-2: _____ CITY: _____

STATE: _____ POSTAL CODE: _____

PHONE: _____ FAX: _____

EMAIL: _____

CLIENT/PATIENT - GENERAL INFORMATION

1. **Type of Disability/Medical Condition/Diagnosis(es)**: _____

   _____

   a. Other Notes: _____

2. **Weight**: _____ **Height**: _____ **Age**: _____ **Sex**: _____

3. **Copy of Patient Demographic Face Sheet:** Yes ☐ No ☐

4. **Cognitive Ability**: Poor: _____ Fair: _____ Good: _____ Excellent: _____ Other: _____

5. **Physical Condition**: Frail: _____ Other: _____

6. **Nutritional Status**: Poor: _____ Fair: _____ Good: _____ Excellent: _____ Other: _____

7. **Feeding**: Naso-Gastric Tube: _____ Gastro-Intestinal: _____ By Mouth: _____

8. **Does the client/patient have round-the-clock caregivers**: Yes: _____ No: _____

9. **Current turning schedule**: 2-hrs: _____ 4-hrs: _____ 6-hrs: _____ 8-Hrs: _____ None: _____

   a. Other Notes: _____

CLIENT/PATIENT - CLINICAL INFORMATION

1. Respiratory

a. Ventilator – Dependent: _____ Ventilator Assisted: _____

b. Pneumonia - Present: _____ Susceptible to: _____

c. History of Pneumonia: Yes ☐ No ☐ No. of times since injury or illness: _____ last 24/months

c. Other Notes: _____

2. Skin

a. Active Pressure Ulcer - Stage-1: _____ Stage-2: _____ Stage-3: _____ Stage-4: _____

b. History of Pressure Ulcers: Yes ☐ No ☐ No. of times since injury or illness: _____ last 24/months

c. Location - Trunk: _____ Extremity: _____

c. Other Notes / History _____

3. Body Positioning

a. Can Client/Patient lay on his/her back - Yes: _____ No: _____

b. If **no**, why not? _____

c. Is Client/Patient contracted (legs) Yes: ___ To What Degree? _____ No: _____

d. Does Client/Patient need to have his/her head elevated all night - Yes: ____How High? _____ No: _____

e. Foot Positioning: Does client have foot drop? Yes: ____ No: ____ Wear heel boots? Yes: _____ No: _____

f. Other Notes: _____

OTHER INFORMATION

1. **Residence / Delivery Information:**

   a. **Home:** _____ Apartment: _____ Condo: _____ Facility: _____

   b. **Floor/Level:** Ground: _____ Other: _____

   c. **Residence Accessibility:** Ramp: _____ Other: _____

   d. **Room Size:** Width _____ Length _____ Total Sq./Ft: _____

   e. **Delivery:** Easy: _____ Difficult: _____

   f. **Assistive Devices:**
      i. Floor Lift: _____ Ceiling Lift: _____

      ii. Wheelchair:_____Other_____

   g. **Do you require / want the mattress fire proof option that meets CA TB 129 (for use in public buildings)?**
      i. **Yes_____ No_____**

2. **Products**
   a. Bed Product Currently Used: _____-_____

   b. Age of product: _____ Condition: _____

   b. Issues / problems: _____

3. **Funding Source**
   a. Private Insurance: _____ Workers' Comp: _____ VA: _____ Private Pay: _____

   b. Contact Name: _____

   c. Contact: Phone Number: _____

   d. Other: _____

4. **Anticipated Delivery Date:** ☐ Within 30-days ARO (after receipt of order) ☐ Other: _____

Other Information (attach more pages if required): _____

Completed By (Print): _____ Signature: _____ ___

DATE: _____

EMAIL COMPLETED FORM TO: info@pro-bed.com or FAX TO: 1-877-852-3097

For ProBed Use Only:
Suggested Freedom Bed Model: _____

Suggested Optional Accessories: _____

Other Notes: _____