

Surgery On Sunday, Inc.
Intake Referral Form

Patient Name:

Last: _____ MI: _____ First: _____ SS#: _____ DOB: _____ Phone: _____

Address: _____ City: _____ County: _____ Zip: _____

If under 18, responsible, Parent/Guardian Name _____ Phone # _____

| | | |
|---|---|---|
| Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female | Marital Status: _____ | Do you have a known Disability? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| # in Household: _____ | Insurance Status: _____ No Insurance _____ Medicare/Medicaid/Private | |
| Annual Income: _____ | Have you ever applied for a medical card? <input type="checkbox"/> Yes <input type="checkbox"/> No Date _____ | |
| Race: <input type="checkbox"/> African Amer. <input type="checkbox"/> Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Native American <input type="checkbox"/> White <input type="checkbox"/> Other | | |

Living Situation: Own Rent Transient: **Employment Status:** Employed Unemployed

REQUIRED DOCUMENTATION BEFORE FIRST SURGICAL CONSULTATION

Medical Records _____ Financial Records _____ (Pay Stub, W-2, Tax Return)

SPECIFIC PROCEDURE/CONSULT REQUESTED FOR PATIENT?

Medical Conditions – Please Specify

| | |
|---------------------------|--------------------------|
| Heart Disease _____ | Diabetes _____ |
| High Blood Pressure _____ | Lung Disease _____ |
| Liver Disease _____ | Kidney Disease _____ |
| Anemia _____ | High Cholesterol _____ |
| Sight Impairment _____ | Hearing Impairment _____ |
| HIV Positive _____ | Other _____ |

Current Medication:

| Name of Drug | Strength | Name of Drug | Strength | Name of Drug | Strength |
|--------------|----------|--------------|----------|--------------|----------|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

Who is taking you home after your surgery/procedure? Name: _____ Phone _____

Report of Procedure/Surgery goes to: _____

Referral Agency: _____ **Referral Date:** _____

Case Manager: _____ **Phone:** _____

| |
|--|
| Interpreter Needed <input type="checkbox"/> Yes <input type="checkbox"/> No Language _____ |
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| Patient Triage <input type="checkbox"/> URGENT (seen w/in 1 month) <input type="checkbox"/> Required (seen w/in 2 months) <input type="checkbox"/> Elective (seen w/in 3 months) |
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