Patient Intake Form – Part One

BENEFICIARY INFORMATION

Patient Name: ______ DOB: ______ Gender: ☐ Female ☐ Male

Address: ______

City: ______ State: ______ Zip: ______

Phone: (home): ______ (cell): ______

Height: ______ Ft. ______ In. Weight: ______ lb.

Insurance: ______ ID#: ______

Policy Holder, if Not Patient: ______ Policy Holder DOB: ______

Name of Legally Responsible Representative: ______

Relationship to Beneficiary: ______

Address: ______

City: ______ State: ______ Zip: ______

Phone: (home): ______ (cell): ______

REFERRING/ORDERING PHYSICIAN

Name: ______ NPI#: ______

Phone: ______

ONCOLOGIST/SURGEON

Name: ______ NPI#: ______

Phone: ______

PCP

Name: ______ NPI#: ______

Phone: ______

QUESTIONS FOR THE BENEFICIARY

Is the beneficiary enrolled in a Medicare HMO/managed care program? ☐ Yes ☐ No

Has the beneficiary been enrolled in a Medicare HMO/managed care program and is returning to FFS? ☐ Yes ☐ No

Has the beneficiary ever received the same or similar supplies/equipment? ☐ Yes ☐ No

If yes, list equipment/supplies? ______

From whom was it purchased? ______ Date purchased? ______

Is the item being replaced? ☐ Yes ☐ No Is there a new medical necessity? ☐ Yes ☐ No

Describe condition for previous need: ______

Describe new/changed condition: ______

Has the beneficiary seen their physician for a breast cancer-related visit in the last 12 months? ☐ Yes ☐ No

Did the beneficiary present with a Detailed Written Order (DWO)? ☐ Yes ☐ No

Did the beneficiary present with timely (< 12 months old) clinical notes? ☐ Yes ☐ No

Reason for Visit: ☐ Pre-Op ☐ Post-Op ☐ 1st Fitting After Surgery ☐ Refit ☐ Order Pick Up ☐ Routine Fitting ☐ Change in Condition ☐ New Surgery ☐ Replacement of Supplies ☐ Lost Supply

BENEFICIARY ASSESMENT

1. Surgery: ☐ LT ☐ RT ☐ LTRT Date: ____

   ☐ Mastectomy ☐ Partial mastectomy ☐ Reconstruction ☐ Other: ________________________

2. Surgery: ☐ LT ☐ RT ☐ LTRT Date: ____

   ☐ Mastectomy ☐ Partial mastectomy ☐ Reconstruction ☐ Other: ________________________

3. Surgery: ☐ LT ☐ RT ☐ LTRT Date: ____

   ☐ Mastectomy ☐ Partial mastectomy ☐ Reconstruction ☐ Other: ________________________

4. Surgery: ☐ LT ☐ RT ☐ LTRT Date: ____

   ☐ Mastectomy ☐ Partial mastectomy ☐ Reconstruction ☐ Other: ________________________

Surgical Scar: ☐ Healed ☐ Not healed Sensitivity/Numbness/Tingling: ☐ Yes ☐ No

Drains: ☐ Yes ☐ No Keloid Scars: ☐ Yes ☐ No

Skin Condition: ☐ Good ☐ Rash ☐ Red/Irritated ☐ Cool ☐ Hot Allergies: ☐ Yes ☐ No

Lymph Nodes: ☐ Sentinel Node Removal ☐ Full Axillary Dissection Result: ____________________________

History of: ☐ Radiation ☐ Lymphedema ☐ Chemotherapy ☐ Range of Motion issues ☐ Arthritis

☐ Other cancer ☐ Hormone Therapy: ____

☐ Other ____

Cognitive Ability: ____

Range of Motion: ____

Activity Level: ☐ Active ☐ Moderately Active ☐ Sedentary

Compliant: ☐ Yes ☐ No ☐ Other: ____

Patient Expectations/Goals: ☐ Symmetry ☐ Comfort ☐ Balance ☐ Other: ________________________

____

____

Visit Outcomes: ____

____

SOAP NOTE:

S:____

____

O:

Current Prosthesis: Size: _____ Style: _____ Mfg: _____ Current Bra: Size: _____ Style: _____ Mfg: _______

Condition of Current Prosthesis: ☐ Good ☐ Not functioning ☐ Too big ☐ Too small ☐ Other ____________

Condition of Current Bra: ☐ Good ☐ Not functioning ☐ Too big ☐ Too small ☐ Other _________________

Current Product Assessment: ____

____

Measurements: Band: ______in. Cup: ______in. Projection: ______in. Symmetry ______in.

A:____

____

P:____

____

Notes:

____

____

____

Items Delivered/Ordered:

HCPCS Code	LT, RT, or LTRT	ITEM NUMBER	SIZE	COLOR	MFG.	TOOK	ORDER	RECEIVED

Patient Intake Form – Part Two

To be completed by the patient:			**Initial**
I was offered a copy of the privacy notice.	☐ Yes	☐ No	_____
I received a copy of the Medicare Standards, either in hard copy format or a link to an electronic copy.	☐ Yes	☐ No	_____
Fitter discussed billing and prices. I understand I am responsible for co-payments/co-insurance/deductibles and to confirm my insurance plan coverage	☐ Yes	☐ No	_____
I authorize release of information to my insurance company and medical provider(s).	☐ Yes	☐ No	_____
I authorize **Babette Maiss** to act as my Agent in helping me obtain payment from my insurance provider(s).	☐ Yes	☐ No	_____
I permit a copy of this authorization to be used in place of the original.	☐ Yes	☐ No	_____
I authorize Babette Maiss to leave a message on my voice mail.	☐ Yes	☐ No	_____
I authorize Babette Maiss to send me reminders and invitations	☐ Yes	☐ No	_____
I am satisfied with the fit and function of the products I received today.	☐ Yes	☐ No	_____
Fitter asked me if I have any questions.	☐ Yes	☐ No	_____
My questions were answered satisfactorily.	☐ Yes	☐ No	_____
Fitter reviewed treatment plan with me.	☐ Yes	☐ No	_____
I received a Patient Satisfaction Survey.	☐ Yes	☐ No	_____
I received written Care Instructions for my device(s).	☐ Yes	☐ No	_____
I will report any physical changes that may relate to the use of my device(s) to my health care provider(s) and Babette Maiss immediately.	☐ Yes	☐ No	_____

Patient's Signature: ___________________________________ Date: __________________

Have a copy of Medicare/Insurance card? ☐ Yes ☐ No

Dispensing Order On Hand? ☐ Yes ☐ No Detailed Written Order On Hand? ☐ Yes ☐ No

Have timely clinical documentation supporting Continued Use? ☐ Yes ☐ No

Have timely clinical documentation supporting Continued Medical Need? ☐ Yes ☐ No

Fitter's Signature: ___________________________________ Date: __________________