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: _____