COSAC Foundation Hospital Intake Form

Name of Institution _____ Hosp Floor _____

Your Name : _____ Fax Number _____

Office number _____ when you are done filling out form fax form to 954-926-2022

Name of your patient _____

Do they have health insurance? **yes or no,** If so what type _____

Do they need home health care? **yes or no,** If so what type _____

and how long do they need it for? _____

Does your client have a job? **yes or no,** if so for how long _____

Date admitted _____ Date for discharge _____

How many days were they in the hospital? _____

Why did they get admitted to the hospital? _____

Do they have any devices to walk or any other device such as tubes, drains or bags ? **yes or no,** if yes what type _____

If they are in a wheel chair or walking device have PT or OT evaluate to see if they can make it down two flights of stairs with a hand rail in case of fire. Can they make it down if we had a fire? **yes or no**

Can the patient work an 8 hour shift? **yes or no,** if not when can they work? _____
Does your patient have a history of Seizures? yes or no
Can the client sleep on the top bunk **yes or no**
Does the client need a bottom bunk **yes or no or N/a**
Can the client sleep on a Fema type Mat five inches thick **yes or no**

Signatures _____ Approval Code: _____

This form is to be faxed to 954-926-2022 or _____

All clients are to come with ten bus passes because the county has restricted bus passes to mostly hospitals. Your patient will be denied entrance if the bus passes are not presented to us when they arrive. Please secure the bus passes, copy of DC summery sheet and this form in a white envelope. Write the words " HAND TO SHELTER STAFF " on the front of the envelope. All clients must have a 30 day supply of medicine.