

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:
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:	

Corporate Office: 602 – 30930 Wheel Avenue, Abbotsford, British Columbia, Canada V2T 6G7 Phone: 800.816.8243 Fax: 877.852.3097

Email: info@pro-bed.com Website: www.pro-bed.com

CLIENT/PATIENT - GENERAL INFORMATION

Weight: Height: Age: Sex: Copy of Patient Demographic Face Sheet: Yes □ No □ Cognitive Ability: Poor: Fair: Good: Excellent: Other: Physical Condition: Frair: Good: Excellent: Other: Nutritional Status: Poor: Fair: Good: Excellent: Other: Nutritional Status: Poor: Fair: Good: Excellent: Other: Peeding: Naso-Gastric Tube: Gastro-Intestinal: By Mouth: Does the client/patient have round-the-clock caregivers: Yes: No: Current turning schedule: 2-hrs: 4-hrs: 6-hrs: 8-Hrs: None: a. Other Notes: Susceptible to: Ventilator Assisted: b. Pneumonia - Present: Susceptible to: Localiator - Dependent: Ventilator Assisted: c. History of Pneumonia: Yes No: No: Istage-4: Istage-3: Stage-4: Istage-4: b. History of Pressure Ulcer - Stage-1: Stage-2: Stage-3: Stage-4: Istage-4: c. Location - Trunk: Extremity: Istage-4: Istage-4: No: b. If no. why not? No: No: No: c. Is Client/Patient contracted (legs) Yes: To What Degree? No:	Face Sheet: Yes	a.	Other Notes:				
Cognitive Ability: Poor: Fair: Good: Excellent: Other: Physical Condition: Frail: Other: Nutritional Status: Poor: Fair: Good: Excellent: Other: Feeding: Naso-Gastric Tube: Gastro-Intestinal: By Mouth: By Mouth: Feeding: Naso-Gastric Tube: Gastro-Intestinal: By Mouth: By Mouth: By Mouth:		Weight	t:	Height:	Age: _		Sex:
Physical Condition: Frail: Other: Other: Other: Other: Other: Other: Good: Excellent: Other: Other: Good: Excellent: Other: Other: Other: Good: Excellent: Other: Other: Other: Gastro-Intestinal: By Mouth: By Mouth: Other: Other: Gastro-Intestinal: By Mouth:	Other:Other:	Сору о	of Patient Demogra	phic Face Sheet: Y	Yes □ No	о 🗆	
Nutritional Status: Poor: Fair: Good: Excellent: Other: Peeding: Naso-Gastric Tube: Gastro-Intestinal: By Mouth: Does the client/patient have round-the-clock caregivers: Yes: No:		Cognit	ive Ability: Poor: _	Fair:	Good:	Excellent:	Other:
By Mouth: By Mouth: By Mouth: Boes the client/patient have round-the-clock caregivers: Yes: No: No: Current turning schedule: 2-hrs: 4-hrs: 6-hrs: 8-Hrs: None: a. Other Notes: Ventilator - CLINICAL INFORMATION	Gastro-Intestinal:	Physica	al Condition: Frail:		(Other:	
Does the client/patient have round-the-clock caregivers: Yes:	No:	Nutriti	onal Status: Poor:	Fair:	Good:	Excellent:	Other:
Current turning schedule: 2-hrs: 4-hrs: 6-hrs: 8-Hrs: None: a. Other Notes: CLIENT/PATIENT - CLINICAL INFORMATION Respiratory a. Ventilator - Dependent: Ventilator Assisted: ventilator Assisted: Ventilator - Dependent: Susceptible to: c. History of Pneumonia: Yes No No. of times since injury or illness: last 24/months. c. Other Notes: 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: last 24/months. c. Cother Notes / History No last 24/months. c. Cother Notes / History last 24/months. c. Location - Trunk: Stage-4: No last 24/months. c. Cother Notes / History No last 24/months. c. Location - Trunk: Stage-3: Stage-4: No last 24/months. c. Location - Trunk: Stage-4: No last 24/months. c. Location - Trunk: Stage-4: No last 24/months. c. Location - Trunk:	S: 4-hrs: 6-hrs: 8-Hrs: None: T/PATIENT - CLINICAL INFORMATION Susceptible to: Yes	Feedin	g: Naso-Gastric Tub	e: C	Gastro-Intestinal:	By M	Youth:
a. Other Notes: CLIENT/PATIENT - CLINICAL INFORMATION Respiratory a. Ventilator - Dependent: b. Pneumonia - Present: c. History of Pneumonia: Yes No No. of times since injury or illness: c. Other Notes: Skin a. Active Pressure Ulcer - Stage-1: b. History of Pressure Ulcers: Yes No No. of times since injury or illness: c. Location - Trunk: c. Location - Trunk: c. Other Notes / History Body Positioning a. Can Client/Patient lay on his/her back - Yes: b. If no, why not? c. Is Client/Patient contracted (legs) Yes: To What Degree? No:	T/PATIENT - CLINICAL INFORMATION Susceptible to: Susceptible to: Yes No No. of times since injury or illness: Stage-1: Stage-2: Stage-3: Extremity: Extremity: On his/her back - Yes: To What Degree? No: d to have his/her head elevated all night - Yes: How High? No: Ventilator Assisted: Stage-4: Stage-4: Stage-4: Extremity: No: No: d to have his/her head elevated all night - Yes: How High? No:	Does th	ne client/patient hav	ve round-the-clocl	k caregivers: Yes:	No:	
CLIENT/PATIENT - CLINICAL INFORMATION Respiratory a. Ventilator – Dependent:	T/PATIENT - CLINICAL INFORMATION Ventilator Assisted:	Currer	nt turning schedule:	2-hrs: 4-h	rs: 6-hrs:	8-Hrs:	None:
Respiratory a. Ventilator – Dependent:	Ventilator Assisted: Susceptible to: Susceptible to: last 24/months	a.	Other Notes:				
Skin a. Active Pressure Ulcer - Stage-1: Stage-2: Stage-3: Stage-4: b. History of Pressure Ulcers: Yes	Stage-1: Stage-2: Stage-3: Stage-4: ers: Yes	a. b.	Ventilator – Deper Pneumonia - Prese	nt:	Susceptible	to:	-
c. Location - Trunk: Extremity: c. Other Notes / History 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:	Extremity:No:No:	Skin					
c. Other Notes / History	on his/her back - Yes: No:	b.	History of Pressure	e Ulcers: Yes \square	No □ No. of tin	nes since injury or illi	ness: last 24/months
Body Positioning a. Can Client/Patient lay on his/her back - Yes:No:	on his/her back - Yes: No:	c.	Location - Trunk:			_Extremity:	
a. Can Client/Patient lay on his/her back - Yes:No:	cted (legs) Yes: To What Degree? No: d to have his/her head elevated all night - Yes:How High? No:	c.	Other Notes / Histo	ory			
c. Is Client/Patient contracted (legs) Yes: To What Degree? No:	cted (legs) Yes: To What Degree? No: d to have his/her head elevated all night - Yes:How High? No:	-		lay on his/her bacl	x - Yes:	No:	
	d to have his/her head elevated all night - Yes:How High? No:	b.	If no , why not?				
		c.	Is Client/Patient co	ontracted (legs) Ye	s: To What De	gree?	No:
d. Does Client/Patient need to have his/her head elevated all night - Yes:How High? No	client have foot dron? Yes: No: Wear heel hoots? Yes: No:	d.	Does Client/Patien	t need to have his/	her head elevated a	ll night - Yes:H	Iow High? No:

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OTHER INFORMATION

	a.	Home::	Apartment:	Co	ndo:	Facility:
	b.					
	c.					
	d.					t:
	e.					
	f.	Assistive De			_ Ceiling Lift	::
		ii. Who	eelchair:	Other		
	g.		uire / want the mate	tress fire proof o	option that mee	ts CA TB 129 (for use in public buildings)
2.	Produc					
	a.	Bed Product	Currently Used:	-		
	b.	Age of produ	ıct:	Condition	:	
	b.	Issues / prob	lems:			
3.		ng Source Private Insur	ance: W	orkers' Comp: _	VA:	Private Pay:
	b.	Contact Nam	ne:			
	c.	Contact: Pho	ne Number:			
	d.	Other:				
4.	Anticip	oated Delivery	Date: Within 30	0-days ARO (afte	er receipt of orde	er) 🗆 Other:
Other 1	nformat	tion (attach m	ore pages if require	ed):		
Compl	eted By ((Print):			Signature:	
DATE:						
				352-3097, OR	AS OTHER	WISE DIRECTED
For I	ProBed U	U se Only: edom Bed Mo	del:			
Sugg	ested Op	tional Accesso	ries:			
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