



FREEDOM BED – PATIENT INTAKE FORM

(Please fill out as much applicable information as you can.)

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: _____

ADDRESS-1: _____

ADDRESS-2: _____

CITY: _____ STATE: _____

COUNTRY: _____ POSTAL CODE: _____

PHONE: _____ FAX: _____

EMAIL: _____

CLIENT/PATIENT - GENERAL INFORMATION

1. **Type of Disability/Medical Condition:** _____
 - a. Other Notes: _____
2. **Weight:** _____ **Height:** _____ **Age:** _____ **Sex:** _____
3. **Cognitive Ability:** Poor: _____ Fair: _____ Good: _____ Excellent: _____ Other: _____
4. **Physical Condition:** Frail: _____ Other: _____
5. **Nutritional Status:** Poor: _____ Fair: _____ Good: _____ Excellent: _____ Other: _____
6. **Feeding:** Naso-Gastric Tube: _____ Gastro-Intestinal: _____ By Mouth: _____
7. **Does the client/patient have round-the-clock caregivers:** Yes: _____ No: _____
8. **Current turning schedule:** 2-hrs: _____ 4-hrs: _____ 6-hrs: _____ 8-Hrs: _____ None: _____
 - a. Other Notes: _____

CLIENT/PATIENT - CLINICAL INFORMATION

1. **Respiratory**
 - a. Ventilator – Dependent: _____ Ventilator Assisted: _____
 - b. Pneumonia - Present: _____ Susceptible to: _____
 - c. Other Notes: _____
2. **Skin**
 - a. Active Pressure Ulcer - Stage-1: _____ Stage-2: _____ Stage-3: _____ Stage-4: _____
 - b. Location - Trunk: _____ Extremity: _____
 - c. Other Notes / History _____
3. **Body Positioning**
 - a. Can Client/Patient lay on his/her back - Yes: _____ No: _____
 - b. Is Client/Patient contracted (legs)- Yes: ____ To What Degree? _____ No: _____
 - c. Does Client/Patient need to have his/her head elevated all night - Yes: ____ How High? _____ No: _____
 - d. Foot Positioning: Does client have foot drop? Yes: ____ No: ____ Wear heel boots? Yes: ____ No: ____
 - e. Other Notes: _____

OTHER INFORMATION

1. **Residence / Delivery Information:**
 - a. **Home::** _____ Apartment: _____ Condo: _____ Facility: _____
 - b. **Floor/Level:** Ground: _____ Other: _____

- c. **Residence Accessibility:** Ramp: _____ Other: _____
- d. **Room Size:** Width _____ Length _____ Total Sq/Ft: _____
- e. **Delivery:** Easy: _____ Difficult: _____
- f. **Assistive Devices:**
 - i. Floor Lift: _____ Ceiling Lift: _____
 - ii. Wheelchair: _____ Other _____
- g. **Other Notes:** _____

2. Products

- a. Bed Product Currently Used: _____
- b. Age of product: _____ Condition: _____
- b. Issues / problems: _____
- c. Other Notes: _____

3. Funding Source

- a. Private Insurance: _____ Workers' Comp: _____ VA: _____ Private Pay: _____
- b. Contact Name: _____
- c. Contact: Phone Number: _____
- d. Other: _____

4. Anticipated Delivery Date: _____

Other Information (attach more pages if required): _____

Completed By (Print): _____ **Signature:** _____

DATE: _____

FAX COMPLETED FORM TO (604) 852 3097, OR AS OTHERWISE DIRECTED.

For ProBed Use Only:

Suggested Freedom Bed Model: _____

Suggested Optional Accessories: _____

Other Notes: _____