HELEN HAYES HOSPITAL

Center for Rehabilitation Technology
Intake Form

Return to FAX: (845) 786-4951 PHONE: (845) 786-4587 **New to HHH ❑** **Known to HHH ❑**

Date of Intake: _____

Patient Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

E-mail: _____

Contact Person: _____

Phone: _____

E-mail: _____

Relationship: _____

Primary Insurance:
❑ Medicare ❑ Medicaid
❑ Private:
_____

Secondary Insurance:
❑ Medicare ❑ Medicaid
❑ Private:
_____

MEDICAL

Diagnosis: _____

_____

_____

Birthdate: _____

MD Name:
_____

❑ RX w/ Dx requested ❑ Insurance Authorization Needed? ❑ Yes ❑ No
Currently resident of nursing home? ❑ Yes ❑ No
Receiving Home Health Services? ❑ Yes ❑ No

Funded by: _____

REASON FOR APPOINTMENT

❑ Seating Mobility ❑ Augmentative Communication
❑ Computer Access ❑ Electronic Assistive Device

1. ❑ Needs a wheelchair
   ❑ Currently has a wheelchair
   If so, power or manual? (circle correct one)
   ❑ Power ❑ Manual

   Age of W/C: _____ Make/model of W/C: _____

   W/C supplier/vendor: _____

   Funder of W/C: _____

2. Needs a communication device ❑ Yes ❑ No

   How does person communicate? _____
   Does person own a AAC device? ❑ Yes ❑ No

   Type: _____ Age: _____ Funded by: _____

3. Needs to access a computer? ❑ Yes ❑ No
   Purpose: ❑ School ❑ Vocational ❑ Leisure
   ❑ Requested school documentation

4. Needs Electronic Assistive Device ❑ Yes ❑ No

   What do you want to control? _____