Interdisciplinary Care Management Form Pre-admission/Pre-screening Data

This form should be completed for new admissions or changes in patient information. Upon completion of this form you can choose to either fax or submit a hard copy to the appropriate location listed below:

	Room#	Fax#	Phone#
1NW Inpatient	1-1655	301-480-3137	301-451-0345
1NW Day Hospital	1-2625	301-480-1063	301-451-7727
1SE(H)Ped Clinic	1-6444	301-480-3714	301-451-9229

If you choose to <u>FAX</u> the form, please call to alert the staff of the pending arrival.

If the patient is to be seen in both day hospital and clinic, please send for to the area the patient is to be seen on day one

*PI/Team: *Fellow *Person to be notified when patient arrives: *Beeper# *Phone# ISOLATION NEEDED ASSISTIVE DEVICES NEEDED:			Required Fields*			
*Bate of admission/visit:*Date of discharge/clinic:*Protocol#*DX*Cycle/Visit#*Name: Last*DB*PirstMiddle*MRN:*S\$#*DOBAge Gender:*Person accompanying patient during inpatient/outpatient stay:*PI/Team:*Fellow*Fellow*Person to be notified when patient arrives:*Beeper#*Phone#				_*Pediatric Clinic (se	elect room type)	
*Date of admission/visit:*Date of discharge/clinic:*Protocol#*DX*Cycle/Visit#*Name: Last First	*Pediatric Day Hos	pital		*Interview Room *Exam Room		
*Protocol# *DX *Cycle/Visit# *Name: Last First Middle *MRN: SS# *DOB Age Gender:	GENERAL INF	ORMATION SI	HOULD BE COMPLETED FOI	R EACH EPISODE (OF CARE	
*Name: Last First Middle *MRN: SS# *DOB Age Gender: Person accompanying patient during inpatient/outpatient stay: *PI/Team: *Fellow *Person to be notified when patient arrives: *Beeper# *Phone# ISOLATION NEEDED ASSISTIVE DEVICES NEEDED: PATIENT EQUIPMENT (circle) VAD or TRACH or G Tube (TYPE AND SIZE): Other: Person completing form: Name: Office Phone# Beeper# Office Phone# Beeper#	*Date of admission/visit:		*Date of discharge/clinic:		<u>-</u>	
*MRN:SS#*DOBAgeGender: Person accompanying patient during inpatient/outpatient stay: *PI/Team:*Fellow *Person to be notified when patient arrives: *Beeper# *Phone# ISOLATION NEEDED ASSISTIVE DEVICES NEEDED: PATIENT EQUIPMENT (circle) VAD or TRACH or G Tube (TYPE AND SIZE): Other: Person completing form: Name: Office Phone# Beeper#	*Protocol#	*DX_		*Cycle/Vi	sit#	
Person accompanying patient during inpatient/outpatient stay:	*Name: Last		_ First	Middle		
*PI/Team: *Fellow	*MRN:	SS#	*DOB	Age	Gender:	
*Person to be notified when patient arrives: *Beeper# *Phone# ISOLATION NEEDED ASSISTIVE DEVICES NEEDED: PATIENT EQUIPMENT (circle) VAD or TRACH or G Tube (TYPE AND SIZE): Other: Person completing form: Name: Office Phone# Beeper#	Person accompanying patien	t during inpatie	nt/outpatient stay:			
*Beeper#	*PI/Team:		*Fellow			
*Beeper#	*Person to be notified when a	natient arrives:				
*Phone# ISOLATION NEEDED ASSISTIVE DEVICES NEEDED: PATIENT EQUIPMENT (circle) VAD or TRACH or G Tube (TYPE AND SIZE): Other: Person completing form: Name: Office Phone# Beeper#	reigon to be nothica when j	<u> </u>	*Beeper#		_	
PATIENT EQUIPMENT (circle) VAD or TRACH or G Tube (TYPE AND SIZE): Other: Person completing form: Name: Office Phone# Beeper#			*Phone#		_	
VAD or TRACH or G Tube (TYPE AND SIZE): Other: Person completing form: Name: Office Phone# Beeper#	ISOLATION NEEDED	A	SSISTIVE DEVICES NEEDED	:		
Person completing form: Name: Office Phone# Beeper#	PATIENT EQUIPMENT (cir	rcle)				
Name: Office Phone# Beeper#	VAD or TRACH or GT	ube (TYPE A	ND SIZE):	Other:		
Office Phone# Beeper#	Person completing form:					
•	Name:		_			
REASON FOR VISIT/ADMISSION (INCLUDE DATE , TIME, TESTS, PROCEDURE, TREATMENT, I	Office Phone#		Beeper#			
	REASON FOR VISIT/A	ADMISSION (IN	ICLUDE DATE , TIME, TESTS	, PROCEDURE, TR	EATMENT, ETC	
INFUSION: SERIAL TEST:	INFUSION:		SERIAL TEST:			
SEDATION BONE MARROW LUMBAR PUNCTURE: DATE TIME	SEDATION BONE	MARROW	_ LUMBAR PUNCTURE: DAT	ГЕ	TIME	

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*Name: Last	First	Middle
Mailing Address:		
Patient home phone#	Cell#	Work#
Email:		
Date of Travel: Arrival	Departure	
Mode of Travel:Plane: Ca	r: Other:	