BENEFICIARY/MEMBER MEDICAL

 **INTAKE FORM**

# 1. BENEFICIARY/MEMBER INFORMATION

**Name: Jeanette Regan\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:2/5/1944 Gender: Female**

**Address: 2646 Mary Lane\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City: Escondido State:\_CA Zip Code:\_92025 Cell#:760-802-3854**

**Insured By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Nurse Advocate: Suzanne Mitchell**

**Insured ID #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Insured Group #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email:** **Jeanette.regan@gmail.com** **Primary Language: English**

# 2. NURSE-ADVOCATE INFORMATION

**Name: Suzanne Mitchell Specialty: Palliative Care**

**Address: 44901 Trotsdale Drive Business Phone #:951-249-3938**

**City: Temecula State: CA Zip Code: 92592 Cell #760-310-5307**

**Nursing License #: RN159399 License Expiration Date: 4/17/2020**

**Start of Care: August 28, 2018**

Email address: anurseforsafeaccess@gmail.com

# 3. PRIMARY CARE PHYSICIANS

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip Code:\_\_\_\_\_\_\_\_\_ Fax #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- |
| **4.** | **MEDICAL INFORMATION – Include ICD-10 codes where appropriate.** |
| **DIAGNOSIS** | ICD-10 CODE | DATE OF ONSET |
|  1. Neuropathy, acute motor
 | G62.81 |  |
| 1. Neuropathy, progressive segmentally demyelinating
 | G62.89 |  |
| 1. Neuropathy, sciatic
 | G57.0 |  |
| 1. Neuropathy, progressive inflammatory
 | G62.81 |  |
| 1. Arthritis, chronic of hand joint
 | M13.84 |  |
| 1. Osteoarthritis, primary unspecified hand
 | M19.049 |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **5. FAMILY AND COMMUNITY BASED SERVICES-Please check all that apply.** |
| **1.****2.****3.**  | **Family close by to help with health care: Yes X No****Friends close by to help with health care: Yes X No****Support Groups: Church Other Clubs: book Club**  |
| **6.** | **LEVEL OF CARE AND SUPPORT Please check only those that apply.** |

None apply: Client lives with spouse and is total independent.

**7. SKILLED SERVICES PROVIDED OR NEEDED**

**NO SKILLED SERVICES PROVIDED OR NEEDED**

# 8. MEDICATION/ PRESCRIPTION DRUGS

 **NO KNOWN ALLERGIES**

 **CURRENT MEDICATIONS:**

 **Name: Gabapentin \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: 300 mg\_\_\_\_\_ Frequency: 3 X daily\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Name: ASA\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_81 mg\_\_\_\_\_ Frequency: once daily\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Name: Aleve and Advil\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_ Frequency: daily as needed (1-2 x daily)**

**9. VITAMINS & SUPPLEMENTS**

 Turmeric

# 10. MEDICAL CANNABIS HISTORY

No History

**11. NUTRITIONAL REQUIREMENTS AND ALCOHOL CONSUMPTION**

 Please include type of diet, method of feeding, amount and frequency. (Example: Vegan/ Wine 1 X day)

 **regular diet/ 1 glass of wine with dinner**

# 12. NURSE ADVOCATION CARE PLAN

 **I do believe the MD prescription is ½ dropper of 20:1 (CBD to THC) twice daily. Client has no cannabis history and agrees to take ¼ dropper twice daily for 1 week and if she has no negative effects, she will increase the dose to ½ dropper twice daily. We will continue to monitor on a weekly basis. Jeanette plans to continue collaborating with her primary MD and quite likely resume some physical therapy.**

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# 13. FUNCTIONAL LIMITATIONS

 **Although there are no major functional limitations at this time, Jeanette is having difficulty with fine hand motor skills like buttons and progressive weakness even when attempting to pick up a small café’ of coffee.**

 **MOTOR:** May include limitations with walking and/or gross motor movement.

 Notes: see above\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **SELF HELP:** May include limitations with activities of daily living such as bathing, toileting, eating, and dressing.

 Notes: See above\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **COMMUNICATIONS/SENSORY:** May include limitations with hearing, speech, and sight.

 **Notes: Increased numbness in hands and ongoing pain in back and multiple joints**

# 14. ACTIVITIES AND EXERCISE

 Jeanette continues to participate in activities as usual. Also see notation above under functional limitations.

**15. MENTAL STATUS**

 Positive, upbeat, trying to make the best of all this.

# 16. DURABLE MEDICAL EQUIPMENT

 **NONE** At time of admission

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  **TYPE** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  **PROVIDER NAME** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |   **FUNDING SOURCE** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

# 17. MEDICAL SUPPLIES1

 **NONE** At time of admission

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  **TYPE** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  **PROVIDER NAME** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |   **FUNDING SOURCE** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**18. THERAPIES/REFERRALS**1

  **Jeanette mentioned she may have more physical therapy. No prescriptions for therapies at time of admission.**

 **Check all that apply and please include date the referral was made and why. If therapy is ongoing, please indicate the current progresss/status in Section 21.**

 Physical Therapy Date:\_**\_\_\_\_\_\_\_** Referral Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Occupational Therapy Date: \_\_\_\_\_\_\_\_\_\_Referral Reason:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Speech Therapy Date: \_\_\_\_\_\_\_\_\_\_ Referral Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Enterostomal Therapy Date: \_\_\_\_\_\_\_\_\_ Referral Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Social Worker Date:\_\_\_\_\_\_\_\_\_\_ Referral Reason\_: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Nutritionist Date: \_\_\_\_\_\_\_\_\_\_ Referral Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other/List:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_ Referral Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other/List:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_ Referral Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**19. TREATMENT GOALS/DISCHARGE PLAN**

**Upon completion of treatment plan, the beneficiary will be able to function independently and maintain self safely in the home setting.**

**Notes: Jeanette is hopeful that prescription medical cannabis will relieve her pain, neuropathy, and decreased hand mobility sufficiently to enable her to carry out her desired activities of daily living independently.**

**As a nurse advocate for safe access, I remain available to assess, evaluate and monitor the effects of medical cannabis until Jeanette feels treatment is complete and discharge is appropriate.**

# 20. TRAINING NEEDS FOR BENEFICIARY/FAMILY

**No training needs have been identified for the beneficiary and/or the family during this treatment period.**

 Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 **21. SUMMARY OF BENEFICIARY STATUS DURING THIS TREATMENT PERIOD**

Please include all data relevant to beneficiary’s care. Notes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# 22. SIGNATURES REQUIRED

 **After completing all sections, please obtain signatures from patient and nurse advocate below:**

**Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Nurse Advocate \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_**



# 23. 1 EXTRA PAGE FOR NOTE TAKING

Please include all data relevant to beneficiary’s care.

Notes:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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