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**](mailto: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

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| **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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