RANCHO LOS AMIGOS NATIONAL REHABILITATION CENTER
Center for Applied Rehabilitation Technology (CART)

Name:_____ Date: _____ Sex: F / M

MRN#: _____ **Primary Language:** _____

Permanent Address

Address: _____ Home Phone #: (____)_____

City: _____ Work# (_____)_____

State: _____ Zip Code: _____ Fax #: (_____)_____

County: _____ Email: _____

Temporary Address (if applicable)

Address: _____ Home Phone #: (____)_____

_____ County: _____

City: _____ State: _____ Zip Code: _____

SSN#: _____ Date of Birth: _____ Age: _____ Marital Status:_____

Birth Place:_____ Race: _____
(State or Foreign Country)

Spouse Name: _____ Parent/Guardian: _____

Patient is a minor: Mom's SSN #:_____ OR Dad's SSN#: _____

Date of Birth:_____ Date of Birth: _____

Mother's Maiden Name: _____ Father's Full Name: _____

Emergency person: _____ Relationship: _____

Address: _____ Home Phone #: (_____)_____

_____ Cell Phone/Pager #: (_____)_____

City: _____ State:____ Zip Code: _____

ICD-10 Code:_____

Medical Diagnosis: _____ Date of Onset: _____

Use Ventilator: Yes / No **Tracheostomy:** Yes / No **Able to speak:** Yes / No

Primary Physician Name: _____ License #: _____ **NPI#:** _____

Address: _____ **Phone #**: ( ) _____

City: _____ State: _____ Zip Code: _____

Consultation Request/Rancho Physician name:_____

Clinic Name: _____ Ext. No:_____

Living Situation: (check one) ☐ Lives independently ☐ Nursing Home (**SNF**) ☐ Hospital

☐ Group facility ☐ Family home ☐ Sub Acute

Daytime Activities: (check one) ☐ Work ☐ Attends School: ☐ Full-time ☐ Part-time

☐ Other (specify)_____

Referral Information: Reason for referral (check all that apply)

☐ Seating ☐ Mobility ☐ Augmentative Communication ☐ Environmental Control

☐ Worksite Evaluation ☐ Access to Computer and Mobile Devices ☐ Other _____

Goals/Expectations: _____

Name of Wheelchair Vendor (if available):
Funding sources: _____

Medicare#: _____ CCS Case #:_____

Part A - eff. date: _____ CCS Authorization #:_____

Part B - eff. date: _____ Other (specify)_____

Medi-cal #: _____ _____

Medi-cal Issue Date:_____ _____

Referral source:

Name: _____ Agency:_____

Address:_____ Phone #: (_____)_____

_____ Cell Phone/Pager #: (____)_____

City: _____ Fax#: (_____)_____

State:_____ Zip Code:_____ E-Mail:_____

Comments: _____

(CART Use only)

Appt. Date: _____ Time: _____ Rescheduled Appt. Date: _____ Time: _____

Scheduled with: _____ Scheduled with:_____

rev: 10.18