Geritom Medical
CREATING WAYS TO BETTER YOUR LIFE

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FACILITY INTAKE

SITE/CONTACT INFORMATION

COMPANY NAME: ____
LOCATION NAME: ____
ADDRESS:____
CITY______________________________STATE___________________ZIP____________
PHONE #_____________________________ FAX #__________________________________
EMAIL(S):____
FACILITY TYPE/LICENSE:____
HOME MANAGER:______________________________PHONE #_______________________
ALTERNATE CONTACT:___________________________PHONE #_______________________
NURSE CONTACT:________________________________PHONE #_______________________

CLINICAL RESOURCES

PACKAGING:☐VIALS ☐NURSING HOME CARDS ☐REMINDER CARDS ☐PARATA ☐NOT SURE

MEDSHEETS: YES______ NO______

SIDE EFFECT SHEETS: YES_____ NO_____

SPLITS (MEDS FOR DAY PROGRAM): YES______ NO______

SPLIT DAY(S) OF WEEK: _________________________ SPLIT TIME(S):______________________

CLOZAPINE/PHLEBOTOMIST NEEDS: YES_____ NO______

MEDICAL SUPPLIES

☐ENTERAL ☐ OSTOMY

☐DIABETIC ☐ UROLOGICAL

☐INCONTINENCE ☐ GLOVES

☐CLEANING SUPPLIES ☐ OTHER______________________________________

PLEASE INCLUDE ALL SIGNED ORDERS OF SUPPLIES YOU WILL BE ORDERING

BILLING INFORMATION

WHERE WOULD YOU LIKE HOUSE ACCOUNT BILLS SENT:
ADDRESS____
CITY______________________________STATE___________________ZIP____________

WHERE WOULD YOU LIKE PATIENT BILLS SENT (if applicable):
ADDRESS____
CITY______________________________STATE___________________ZIP____________