Geritom Medical
CREATING WAYS TO BETTER YOUR LIFE

ACHC ACCREDITED

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Clozapine Client Intake

1. Patient Information:

Patient Name_____ **Birthdate**_____ **Sex** Male □ Female □
Social Security #_____ **Phone #**_____ **Email**_____
Address_____ **City**_____ **State**_____ **Zip**_____
Referred By_____ **Case Manager**_____ **Phone #**_____
Emergency Contact_____ **Relationship**_____ **Phone #**_____

2. Insurance & Billing Information: (Please Include Copies of Insurance Cards if Available)

MA#_____ **Other Insurance**_____
Cardholder ID #_____ **Group #**_____
Insurance Phone #_____ **Person Responsible for Payment**_____
Relationship_____ **Phone #**_____

3. Medical Information:

Do you have any allergies? No □ Yes □ Please list them_____
Current Pharmacy_____ **Phone #**_____ **City**_____
Primary Doctor_____ **Phone #**_____ **Clinic** _____
Clozapine Doctor_____ **Phone #**_____ **Clinic**_____

4. Diagnosis & Clinical Information:

Current Frequency of Phlebotomy Services: Every Week □ Every 2 Weeks □ Every 4 Weeks □

Current Clozapine Pharmacy: _____ Phone Number _____

Would you like Geritom's Phlebotomist to schedule lab draws?
Yes □ No □ (If no, facility/clinic is responsible for sending labs to Geritom before each dispensation of Clozapine)

If available, please provide any pertinent labs:
Absolute Neutrophil Count (ANC) _____ Date_____

5. Packaging & Medical Supplies:

Vials □ Reminder Cards □ NH Cards □ Not Sure □
Med Sheets: Yes □ No □
Medical Supplies_____

6. Patient/Caregiver Signature:

Patient Signature:_____ **Date:**_____