<table>
<tr><td colspan="6">THE LAKES HOME HEALTH SERVICES, INC.
REFERRAL/INTAKE FORM</td></tr>
<tr><td colspan="6">Tel. (661) 771-7221 * Fax. (855) 832-0130</td></tr>
<tr><td colspan="6">DISCIPLINE:</td></tr>
<tr><td>SN</td><td>PT</td><td>OT</td><td>ST</td><td>HHA</td><td>MSW</td></tr>
<tr><td colspan="6"></td></tr>
<tr><td colspan="2">DATE OF REFERRAL:</td><td colspan="2">NOTES:</td><td colspan="2">SOC DATE:
ROC DATE:</td></tr>
<tr><td colspan="2">SN FREQUENCY:</td><td colspan="2"></td><td colspan="2">EPISODE STATUS: EARLY LATE</td></tr>
<tr><td colspan="2"></td><td colspan="2"></td><td colspan="2">NEW RE-ADMIT RECERT</td></tr>
<tr><td colspan="2"></td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td colspan="2">REFERRAL SOURCE:</td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td colspan="6">PATIENT INFORMATION</td></tr>
<tr><td colspan="6">PATIENT'S NAME: DATE OF BIRTH:</td></tr>
<tr><td colspan="6">ADDRESS:</td></tr>
<tr><td colspan="6">CITY/ZIP/COUNTY:</td></tr>
<tr><td colspan="6">HOME PHONE CELL PHONE</td></tr>
<tr><td colspan="6">SOCIAL SECURITY</td></tr>
<tr><td colspan="6">Male Female MARITAL STATUS: M D W S</td></tr>
<tr><td colspan="6">PRIMARY LANGUAGE ENGLISH SPANISH OTHER:</td></tr>
<tr><td colspan="6">SPECIAL COMMUNICATIONS ACCOMMODATIONS NEEDED: No Yes: specify:</td></tr>
<tr><td colspan="6">EMERGENCY CONTACT</td></tr>
<tr><td colspan="6">INSURANCE INFORMATION</td></tr>
<tr><td colspan="3">MEDICARE OTHER</td><td colspan="3">SECONDARY INSURANCE:</td></tr>
<tr><td colspan="3">MEDICARE NUMBER</td><td colspan="3">POLICY NUMBER</td></tr>
<tr><td colspan="3">STATE MEDICAID</td><td colspan="3">TELEPHONE NUMBER</td></tr>
<tr><td colspan="6">PHYSICIAN INFORMATION (PECOS VERIFY MD)</td></tr>
<tr><td colspan="6">ORDERING PHYSICIAN</td></tr>
<tr><td colspan="6">TELEPHONE NUMBER FAX NUMBER</td></tr>
<tr><td colspan="3">DIAGNOSIS:</td><td colspan="3">HOSPITAL/FACILITY INFORMATION</td></tr>
<tr><td colspan="3">1.</td><td colspan="3">FACILITY</td></tr>
<tr><td colspan="3">2.</td><td colspan="3">ADMIT DATE D/C DATE</td></tr>
<tr><td colspan="3">3.</td><td colspan="3">SURGERY</td></tr>
<tr><td colspan="3">4.</td><td colspan="3">PROCEDURES</td></tr>
<tr><td colspan="6">Any Risk factors for workplace violence (ie. HX violence/threatening behavior/meds): NO Yes</td></tr>
<tr><td colspan="6">MEDICATIONS:</td></tr>
<tr><td colspan="6">NKA ALLERGY:</td></tr>
<tr><td colspan="6">HOME HEALTH CARE ORDERS</td></tr>
<tr><td colspan="6">SERVICES REQUIRED RN PT OT ST HHA MSW</td></tr>
<tr><td colspan="6">EQUIPMENT NEEDED</td></tr>
<tr><td colspan="6">DME COMPANY SUPPLIES NEEDED</td></tr>
<tr><td colspan="6">Have HOME HEALTH SERVICES BEEN AUTHORIZED IN THE PAST? YES NO
IF YES, AGENCY NAME/DATE:</td></tr>
<tr><td colspan="6">SIGNATURE OF PERSON COMPLETING FORM:</td></tr>
<tr><td colspan="6">SIGNATURE OF RN VERIFYING VERBAL ORDERS:</td></tr>
</table>

Intellectual Property rights of the trademark for Beyond Faith Consulting