

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

Name: _____

Date: _____ Sex: F / M

RLANRC#: _____

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: _____

Medical Diagnosis: _____ **Date of Onset:** _____

Use Ventilator: Yes / No

Tracheostomy: Yes / No

Able to speak: Yes / No

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

(Only for Medicare patients)

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 Computer Access
 Worksite Evaluation EADL (electronic aids for daily living) Other _____

Goals/Expectations: _____

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 #: (____) _____
City: _____ Cell Phone/Pager #: (____) _____
State: _____ Zip Code: _____ Fax#: (____) _____
E-Mail: _____

Comments: _____

(CART Use only)

Appt. Date: _____ Time: _____ Rescheduled Appt. Date: _____ Time: _____
Scheduled with: _____ Scheduled with: _____