HAMMERMAN & GAINER

NURSE CASE MANAGEMENT TRIAGE INTAKE FORM

CLIENT: _____ SSN: _____

CLAIM #: _____ DOI: _____

ADDRESS: _____ DOB: _____

_____

_____ SUPERVISOR: _____

PHONE: _____ DIAGNOSIS: _____

REASON FOR REFERRAL:

_____

_____

OVERVIEW:

Age: _____ Sex: _____ Height: _____ Weight: _____

Brief history/date of injury:

_____

_____

_____

_____

_____

_____

_____

Medical Treatment (If Any):

_____

_____

_____

_____

Current Complaints:

_____

_____

_____

_____

_____

_____

Physical Limitations:

_____	☐ Sitting	_____	☐ Kneeling
_____	☐ Standing	_____	☐ Lifting
_____	☐ Walking	_____	☐ Reaching
_____	☐ Climbing	_____	☐ Driving
_____	☐ Balance	_____	☐ Vision
_____	☐ Grip Strength	_____	☐ Hearing
_____	☐ Right Handed	_____	☐ Speech
_____	☐ Left Handed	_____	☐ Sensation
_____	☐ Bending/Twisting	_____	☐ Breathing
_____	☐ Stooping/Squatting	_____	☐ Bowel/bladder
_____	Other		

MEDICAL HISTORY:

Previous Injuries: _____
Previous Surgeries: _____
Hospitalizations: _____

Major illnesses or unrelated medical problems: (HTN, diabetes, heart disease, etc.)

_____
_____

IMPRESSION AND SUMMARY:

_____
_____
_____
_____

RECOMMENDATIONS:

- Needs Emergency Treatment: Referred To:

_____
_____
_____
_____
_____

- Needs Follow up Care- Refer to Concentra:

_____
_____
_____
_____

- No additional Treatment Required: (Supervisor to complete incident report)

_____
_____
_____