Long Term Pharmacy Solutions, Inc.

NEW NON-HOSPICE PATIENT ADMISSION SHEET (Single Patient)

Name of person completing this form ____________________ (Please Print)

Facility name:	Today's Date:

PATIENT INFORMATION

Patient's Last Name: First:	Sex: ❑ M ❑ F	DOB: / /	Social Security #: (not for employees that are patients)

Street Address:	City:	State:	Zip code:

Phone #: ( )	Drug Allergies: ❑ No known allergies (NKA)

Diagnosis: (please list all & use other side if needed)	Other Medical Conditions:

Does Patient attend a Day Program or have they ever resided in a LTC Facility?

❑ Day program ❑ Long Term Care Facility Date discharged: / /

If applicable, Please note name, address & phone number.

INSURANCE INFORMATION

Primary Insurance: (attach a copy of the card)	Card #:	Member ID #:
Secondary Insurance: (attach a copy of the card)	Card #:	Member ID #:

PHYSICIAN INFORMATION

Primary Care Physician's Last Name: First:	Phone #: ( )	Fax #: ( )

Street Address:	City:	State:	Zip code:

Specialist's/OtherPhysician's Last Name: First:	Phone #: ( )	Fax #: ( )

Street Address:	City:	State:	Zip code:

BILLING INFORMATION

Name of Responsible Party (Rep Payee):	Phone #: ( )	Relationship to Patient:

Street Address:	City:	State:	Zip code:

HOUSE INFORMATION

House Manager:	Fax #: ( )	Cell phone #: ( )

Manager's e-mail address:	House e-mail address:

NOTES

It's okay to attach a patient fact sheet/emergency sheet to this form instead of handwriting it, however please make sure that all information requested on this form is included on the fact/emergency sheet.