

# RECORD OF INQUIRY

Name of Prospective Resident		First Name	Middle Name	Sex M      F	Age
Address		City	State	Zip	Phone
Diagnosis				Patient Now At:	
Resident's Physician				Phone	
<input type="checkbox"/> Mentally Alert	<input type="checkbox"/> Ambulatory	<input type="checkbox"/> Bed-Ridden	<input type="checkbox"/> Incontinent	<input type="checkbox"/> Requires Special Diet	
<input type="checkbox"/> Slightly Forgetful	<input type="checkbox"/> Walks With Assistance	<input type="checkbox"/> Requires Bedrails	<input type="checkbox"/> Feeds Self	<input type="checkbox"/>	
<input type="checkbox"/> Confused	<input type="checkbox"/> Chair-Ridden	<input type="checkbox"/> Continent	<input type="checkbox"/> Requires Help w/Feeding	<input type="checkbox"/>	
Additional Information					
Admission Desired on		Accommodation <input type="checkbox"/> Semi-Private <input type="checkbox"/> Private	Rate \$	Per	Referred by:
Name of Inquirer			Relationship		
Address		City	State	Zip	Phone
Remarks					
Date		Interviewed by:			

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