# MEDISYS
REHABILITATION, INC.

# PATIENT INFORMATION FORM

***Services Requested (Please check each service needed)***

____ **Life Care Plan** ____ **Neuropsychological (NPE)** ____ **Psychological** **Date Report Needed By:** / /

____ **Cost Analysis** ____ **File Review Only** ____ **Other**

***Patient Information***

| | | | |
|---|---|---|---|
| **Patient Name:** | ____________ | **Date of Birth:** | / / |
| **Address:** | ____________ | **Patient SS#:** | / / |
| **City/State/Zip:** | ____________ | **Primary Language:** | ____________ |
| **Home Phone:** | ( ) | **Secondary Language:** | ____________ |
| **Work Phone:** | ( ) | **Race:** | ____________ |
| **Cell Phone:** | ( ) | **Sex:** | ____________ |
| **Email Address:** | ____________ | ______ ***Check here if patient should not be contacted personally*** | |

***Primary Contact Person (person we should contact if patient is a child or cannot provide information about their injury/care)***

| | | | |
|---|---|---|---|
| **1st Contact Person:** | ____________ | **Home Phone:** | ____________ |
| **Relationship to Patient:** | ____________ | **Cell Phone:** | ____________ |
| **Address** | ____________ | **Other Phone:** | ____________ |
| **City/State/Zip** | ____________ | **Email address:** | ____________ |

| | | | |
|---|---|---|---|
| **2nd Contact Person:** | ____________ | **2nd Contact Phone:** | ____________ |
| **Relationship to Patient:** | ____________ | **Home Phone:** | ____________ |
| **Address** | ____________ | **Other Phone:** | ____________ |
| **City/State/Zip** | ____________ | **Email address:** | ____________ |

***Injury Information and Medical Records***

*Check all injuries that apply* ___ **Brain Injury** ___ **Paraplegia** ___ **Quadriplegia** ___ **Amputee** ___ **Cerebral Palsy** ___ **Brachial Plexis** ___ **Other**

Please provide a brief
description of injury:

**Date of Injury:** / /

***Referral Source or Attorney Information***

| | | | |
|---|---|---|---|
| **Attorney Name:** | ____________ | **Office Location:** | ____________ |
| **Attorney Firm Name:** | ____________ | **Paralegal Name:** | ____________ |
| **Direct or Mobile phone:** | ____________ | **Paralegal Email:** | ____________ |
| **Attorney email address:** | ____________ | **Paralegal Phone:** | ____________ |

**Style of the case:** ***Please check one:*** ___ Plaintiff ___ Defense

***Please send the completed form to our office along with the fee schedule contract, retainer, medical records and questionnaires (if LCP or NPE).***
***Please feel free to contact us by phone or email at any time.***


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