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|  | | | | | | Original Date: | | | |  | |
| Initials of ED employee | | | |  | |
| Transitions of Care: Initial Data Collection Form | | | | | | | | | | | |
| Name (Last, First, M.I.): |  | | | 🞎 M  🞎 F | | | DOB: **Age:** | | **Race:**  **White** 🞎  **Black** 🞎  **Hispanic** 🞎 **Somolian** 🞎  **Asian** 🞎  **Other:\_\_\_\_\_\_\_\_\_\_\_** | | |
| **Patient’s Telephone:** |  | | | **Allergies:** |  | | | | | | |
| Patient’s Address |  | | | Primary physician:  If none then where d o you go? | | | |  | | | |
| Education Level | Elementary-8th 🞎  High school no degree 🞎  High school 🞎  College degree 🞎  Post Graduate 🞎 | | Insurance Coverage Y 🞎  N 🞎  If Yes what :\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Service Selection:**  🞎 Pharmacy only 🞎 Pharmacy plus home heath | | | | | | | |
|  | | | | | | | | | | | |
| Are you employed? | | Yes 🞎 No 🞎 | | | | | | | | | |
| How many pharmacies do you use? | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pharmacy Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |
| Have you visited an ED in the last month? | | Yes 🞎 No 🞎 | | | | | | | | | |
| Have you visited an ED in the last year? | | Yes 🞎 No 🞎 | | | | | | | | | |
| How many times per week do you leave your house? | |  | | | | | | | | | |
| **What form of transportation do you use?** | | Bus 🞎  Car 🞎  Walk 🞎  Taxi 🞎  Other | | | | | | | | | |
| Primary Diagnosis (Reason for visiting ED) | |  | | | | | | | | | |
| Medications initiated at ED Visit | |  | | | | | | | | | |
| logo | | | | | | | | | | | |
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| Current Medication List | | | | |
| Medication | Strength | Prescribed instructions | Patient regimen | Comments |
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