



Rancho Los Amigos National Rehabilitation Center
Rancho Los Amigos Violence Recovery and Prevention Program
Intake Form

Today's Date _____ **Rancho Admission Date:** _____

Primary Language: _____

Name of patient: _____ Medical record# _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone Number: _____

Alternate phone Number with area code: _____

Emergency contact _____ Phone Number: _____

Age: _____

DOB: _____

Peer Counselor (for office use only): _____



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Gender: M-F or other: _____

Marital Status: _____ Do you have Children? How many: _____

Hospital that you were transferred from: _____

Date of Injury: _____

Where did the incident happen: _____

Level of Injury: _____

Mechanism of Injury: _____

Discharge Date:

Reason for not qualifying: _____

Referred

by;

- Doctor/Nurse
- Social Worker
- Psychologist
- Case manager
- Peer Mentor
- Researcher
- PT/OT/RT
- Other _____

Completed referral form to be given to: Juan Garibay

Rancho Research Institute - Trailer F3 or Scan and e-mail to: juang@ranchoresearch.org