

PATIENT INFORMATION SHEET

Referral _____ Phone # _____
 Order Date _____ Discharge Date _____ CSR _____

Patient _____ Phone # _____
 Date of Birth _____ Soc Sec # _____
 Sex _____ Height _____ Weight _____
 Address _____

Is this the patient's permanent address? _____ Pres location _____
 Delivery Address _____
 Care Give/Relative _____ Relationship _____
 Address _____ Phone # _____

Patient Dx _____
 Physician _____ Phone # _____
 Address _____ UPIN # _____

Insurance #1 _____ Phone # _____
 Insured Name _____ Responsible Party _____
 Policy Info _____ Employer _____
 Insurance #2 _____ Phone # _____
 Insured Name _____ Responsible Party _____
 Policy Info _____ Employer _____
 Insurance #3 _____ Phone # _____
 Insured Name _____ Responsible Party _____
 Policy Info _____ Employer _____
 Medicaid Waiver Authorization # _____

Equipment: DME Oxygen Nutrition **Ostomy** Supplies Other

_____ Length of need **(1-99months)** _____
 _____ Length of need **(1-99months)** _____
 _____ Length of need **(1-99months)** _____
 _____ Length of need **(1-99months)** _____

Oxygen Levels PO2 _____ O2 SAT _____ Test Dale _____
 Nutrition _____ calories per month

DME Prior Rent History? Y N _____
 Does patient own Medical Equipment? Y N _____
 Patient or Spouse Employed? Y N _____
 Is patient or spouse enrolled in an HMO? Y N _____
 Is injury/illness work or accident related? Y N _____
 Is patient aware of copay and deductible? Y N _____