New Patient Order

To: Customer Service Intake
Fax: **724-224-9124**

Date: ______________________ Date Equipment is Needed: ________________

From: ________________________________ Ordering Doctor: ____

Facility: ____ *(Please attach Rx & any medical notes required)*

Phone: ________________________ Fax: ______________________

Patient's Information

Social Security ID# ____________________________________ DOB ____________________

NAME ____ PHONE __________________

ADDRESS ____

Clinical Information

PCP: ____ **PCP PHONE: #**______________________

PRIMARY INS: _________________________**ID #**________________________________ **GRP #**__________

SECONDARY: _________________________**ID #**________________________________ **GRP #**__________

HEIGHT ___________ **WEIGHT** ___________ *(approximate)* **SEX:** M or F *(please circle)*

ANY INFECTIOUS DISEASE PRESENT: If Yes, please specify DX: ____

____

(please list all patient's diagnosis)

Has the Patient ever received equipment before: ***If Yes, please specify:*** _________________________________

EQUIPMENT BEING ORDERED: ____

____

____

Alternate / Emergency Contact: (Name / Address / Phone)

____

Equipment Length of Need: (99/lifetime) or other: __________

____

Physician Signature **Date**

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DME/Rehab - Specialty Products - Respiratory - Medical Supplies - Pharmacy - Home Accessibility Aids

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