

DME *REFERRAL FORM*

PHONE: 860 432-4995 FAX: 781-561-7225

CSR					ORD	ER DATE		NEI	ED BY:	
Referr	al Requested By:					<u>. </u>		PH	ONE:	
HOW I	OID YOU HEAR ABO	UT CHA	RM?					•	1	
PATIENT NAME:						ORGANIZATION:				
ADDRESS:					TELEPHONE: (H)					
						(C)				
SOCIAL SECURITY #: GENDER: \square M \square F				F	DOB:		HEIGHT	WEIGHT:		
DIAG(S): 1) 2)					3)		4)			
DOES PATIENT, OR ANY OTHER PERSON IN THE RESIDENCE HAVE A COMMUNICABLE DISEASE? □ Y □ N						IF YES, PLEASE DESCRIBE:				
PRIMARY INSURANCE:					SECONDARY INSURANCE:					
MEMBER ID #:					MEMBER ID #:					
SAME / SIMILAR: Has the patient received this type of equipment within the previous <u>5</u> years?					ABN WAIVER NEEDED? ☐ Y ☐ N					
OTHER SUPPLIER: Is patient currently with another supplier? \Box Y \Box N						If YES, please list name of company, type(s) of equipment patient has:				
SAME	/ SIMILAR M/C v:			_	N N					
<u>SAME</u>	/SIMILAR MH			_ _ Y [N					
				_	N	SPOKE WITI	Н			REF#
PRIMARY PHYSICIAN:						ORDERING PHYSICIAN:				
PHON	IE#:	F	AX:			PHONE#:			FAX:	_
ADDRESS:					ADDRESS:					
			EMEDCE	NCV CONT	гаст	NEVT OF VI	IN INFORM	ATION		
NAME: —EMERGENCY CONTACT/ ADDRESS:					TELEPHONE: (H)					
RELAT	TIONSHIP:									(C)
						NT REQUES				
Elec Bed Manual Bed Std w/c Light weight w/c Hvy Duty w/c Recliner w/c w/c cushion W/C SIZES: 16in, 18in 20in 22in ELR's FTRS Walker Walker /wheels St. Cane Large Quad Cane										
Sm Quad Cane Crutches Forearm Crutches 3-1 commode RTS RTS w/arms										
Bathseat w/back Transfer Bench										
SPECIAL DELIVERY/PATIENT NOTES:										