

# DME New Patient Form

Send this completed form to [wecare@finneganhealth.com](mailto:wecare@finneganhealth.com)

## 1 REFERRER

Referrer Name: \_\_\_\_\_  
 Facility: \_\_\_\_\_  
 City: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Email: \_\_\_\_\_

## 2 CLINIC

Physician's Name: \_\_\_\_\_  
 Clinic/City: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 NPI#: \_\_\_\_\_

## 3 PATIENT INFORMATION

*providing Facesheet is an accepted alternative*

Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Sex: M F  
 Phone #: \_\_\_\_\_  
 Email: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City/State/Zip: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_  
 Contact #: \_\_\_\_\_ Relationship: \_\_\_\_\_  
 Diagnoses: \_\_\_\_\_

**PASSE:** Summit AR Total Care Empower  
 Medicaid #: \_\_\_\_\_  
 Medicare #: \_\_\_\_\_  
 Does patient get home health care (Medicare only)? Y N  
 Insurance Company: \_\_\_\_\_  
 Phone #: \_\_\_\_\_  
 Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
 Does patient need automatic shipment? Y N  
 How often? Monthly Every other month Quarterly

Refills Are: 6(Medicaid) or 12(Medicare or private insurance) **unless otherwise noted**

## 4 SUPPLY TYPES & DETAILS

INCONTINENCE		
PRODUCT	SIZE/WEIGHT	QUANTITY
Diapers	/	per day
Pull-Ups	/	per day
Bladder Pads	light reg xtra xtra+	per day
Bed/Chair Pads	N/A	per day

**DIABETIC**  
 Meter Brand: \_\_\_\_\_  
 # times checking per day: \_\_\_\_\_  
 Type of meds: *insulin oral*  
 Pregnant? Due date: \_\_\_\_\_  
 Strips & lancets per day: \_\_\_\_\_  
 Lancet Device

**SAFETY + MOBILITY**  
 Shower Hose Commode Chair  
 Grab Bars Bath Chair  
*Please select type:* Transfer Bench  
 suction cup Rolling Walker  
 12" 19 3/4" Quad Cane  
 screws 12" 16" 18" 24"

**On these supply types, we'll contact the patient for needed info:**

**CATHETERS OSTOMY** | **TRACHEOSTOMY WOUND CARE**

**ADD ON ITEMS**  
 Gloves (8 boxes) S M L XL  
 Wipes  
 Raised Toilet Seat

M.D. / APRN signature \_\_\_\_\_ date \_\_\_\_\_