

New Patient Form

Fax to 501-663-6668. We'll take care of the rest. Form also available at: finneganhealth.com/forms

1 REFERRER

Referrer Name: _____
 Facility/City: _____
 Phone #: _____
 Email: _____

2 CLINIC

Physician's Name: _____
 Clinic/City: _____
 Phone #: _____
 Diagnoses: _____
 Refills Approved: 6 12 (twelve = Medicare only)

3 PATIENT INFORMATION

Name: _____
 Date of Birth: _____ Sex: M or F
 Phone #: _____
 Email: _____
 Address: _____
 City/State/Zip: _____
 Emergency Contact: _____
 Contact #: _____ Relationship: _____

Medicaid #: _____
 Medicare #: _____
 Does patient get home health care (Medicare only)? Y or N
 Insurance Company: _____
 Phone #: _____
 Policy #: _____ Group #: _____
 Does patient need automatic shipment? Y or N
 How often? Monthly Every other month Quarterly

4 SUPPLY TYPES & DETAILS

INCONTINENCE

PRODUCT	SIZE/WEIGHT	QUANTITY
<input type="checkbox"/> Diapers	/	per day
<input type="checkbox"/> Pull-Ups	/	per day
<input type="checkbox"/> Bladder Pads	light reg xtra xtra+	per day
<input type="checkbox"/> Bed/Chair Pads	N/A	per day

DIABETIC

Meter Brand: _____
 # times checking per day: _____
 Type of meds: *insulin* or *oral*
 Pregnant? Due date: _____
 Strips & lancets per day: _____

SAFETY + MOBILITY

- Shower Hose Commode Chair
- Raised Toilet Seat Bath Chair
- Grab Bars Transfer Bench
- Please select type:* Rolling Walker
- suction cups / screws Quad Cane
- 12" / 24" Rollator w/ Seat

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

- CATHETERS
- OSTOMY
- TRACHEOSTOMY
- WOUND CARE

OTHER

- Gloves
- Wipes

M.D., APN, or PA signature + date: _____