Finnegan HEALTH SERVICES
6805 W. 12th Street, Suite F
Little Rock, AR 72204
Toll-Free: **1-888-789-6600**
Fax: **501-663-6668**

FHSID | **WEB**

# 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 F

**Phone #:** ____________________

**Email:** ____________________

**Address:** ____________________

**City/State/Zip:** ____________________

*Emergency Contact:* ____________________

*Contact #:* ____________ *Relationship:* ________

**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

## 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: ______

### SAFETY + MOBILITY

Shower Hose
Raised Toilet Seat
Grab Bars
*Please select type:*
suction cup screws
12" 24"

Commode Chair
Bath Chair
Transfer Bench
Rolling Walker
Quad Cane
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. signature + date:** ____________________