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

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 #: _____

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: _____

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

☐ Grab Bars

Please select type:

☐ suction cup

☐ 12" ☐ 19 3/4"

☐ screws ☐ 12" ☐ 16" ☐ 18" ☐ 24"

☐ Commode Chair

☐ Bath Chair

☐ Transfer Bench

☐ Rolling Walker

☐ Quad Cane

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** _____