Finnegan HEALTH SERVICES

1501 N. University Ave | Suite 400
Little Rock, AR 72207
Toll-Free: **1-888-789-6600**
Fax: **501-663-6668**

DME New Patient Form

Send this completed form to 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

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** ______________________