HOMECARE DIMENSIONS

12500 Network Blvd., Ste. #210
San Antonio, TX 78249-3301
Phone: 210.696.2626 | Toll free: 1.888.833.2323
Fax: 210.694.7800

❑ New Referral ❑ Existing Patient Order(s)

❑ Austin	❑ Corpus Christi	❑ Dallas	❑ El Paso	❑ Fort Worth	❑ San Antonio	❑ RGV
512.973.9323	**361.854.3915**	**682.708.3807**	**866.946.9026**	**682.708.3807**	**210.694.7800**	**956.627.0724**

Referred by: _____ Phone: _____ Time/Date: _____

Patient Name: _____ ❑ M ❑ F D.O.B.: _____ Ht: _____ Wt: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ DX: _____ SS #: _____ SOC: _____ LON: _____

D/C Date: _____ Hospital: _____ Room: _____ Allergies: ❑Y ❑ N

Emergency Contact: _____ Relationship: _____ Phone: _____

Primary Insurance: _____ ID#: _____ Group#: _____

Secondary Insurance: _____ ID#: _____ Group#: _____

❑ Nebulizer with Kit

❑ Bedside Commode

❑ *Manual Wheelchair sz _____

❑ *Walker sz _____

❑ *Cane sz _____

❑ *Hospital Bed sz _____

❑ Gel Mattress Overlay

❑ Low Air Mattress

❑ Home Sleep Test with Titration 5–20cm

❑ Other _____

❑ Oxygen _____ O2 Sat@Room Air _____ LPM _____ Freq. _____

❑ **CPAP _____ Supplies _____

❑ **BiPAP: IPAP _____ EPAP _____ Supplies _____

❑ Powered Wheel Chairs

❑ Enteral Feeding: ❑ Pump ❑ Bolus

Formula _____ cc x hrs _____ cans / day _____

❑ NPWT

Gause sz _____ Foam sz _____ Canister sz _____

Notes: _____

*height & weight required **please submit sleep study

❑ Skilled Nursing _____ ❑ Speech Therapy _____ ❑ Home Health Aide _____

❑ Occupational Therapy _____ ❑ Physical Therapy _____ ❑ Medical Social Worker _____

Service/Notes: _____

By signing below you acknowledge receiving the above mentioned products and/or services and proper instructions on the use and care of the products provided. You further agree that you received our Patient Packet containing the Medicare Supplier Standards, Patient Rights and Responsibilities and our Emergency Contact information. You also agree to assign payment for the above products and/or services to us and that payments from your insurance do not typically cover the full cost of the items you are receiving now or in the future. By accepting the products and/or services above, you or your estate agrees to be financially responsible for these items. If your place of residence changes, your insurance coverage changes and/or terminates, you agree to notify us immediately and make appropriate arrangements for payments or to return the equipment voluntarily. You also authorize the release of any medical information needed to process any claims for reimbursement related to the equipment listed above.

Patient Name: _____ Patient Signature: _____ Date: _____

Physician Name: _____ Physician Signature: _____ Date: _____

Clinic: _____ Phone: _____ Fax: _____

Thank you for your referral! Homecare Dimensions, Inc.