American HOME HEALTH CARE INC.

PATIENT INFORMATION AND EQUIPMENT ORDER FORM

Referral Information

Date **Referral Source** **Caller's Name** **Phone**

Patient Information

Name

Address

City **State** **Zip**

Phone **Social Security #**

Gender **Date of Birth** **Height** **Weight**

Diagnosis

2nd Diagnosis

3rd Diagnosis

Caregiver Information

Name

Address

City **State** **Zip**

Relationship

Home Phone **Work Phone** **Cell/Mobile Phone**

Insurance Information

PRIMARY **Policy No.** **Group No. or Company**

Address

City **State** **Zip**

Phone

SECONDARY **Policy No.** **Group No. or Company**

Address

City **State** **Zip**

Phone

Physician Information

Name

Address

City **State** **Zip**

Phone **UPIN**

3430 Tarheel Drive, Suite 104, Raleigh, NC 27609 • PO Box 20342, Raleigh, NC 27619 • 919-876-4336 • fax 919-876-4485 • www.americanhhc.com

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Equipment Order

❑ **Oxygen**

❑ **O_2 concentrator** ❑ **Portable** ❑ **Conserving Device**

LPM:

Blood Gas/PO_2 Result:

Pulse Ox Sat. % Result:

Date of ABG: **Place:**

❑ **CPAP** ❑ **BIPAP**

Type of Mask: **Apnea Events/hr:** **Setting (cm/H_2O):**

❑ **cool or** ❑ **heated humidification**

❑ **Enteral Feeding**

Type of food needed: **cc/hr:**

❑ **Nebulizer**

❑ **Bedside Commode** ❑ **3 in 1** ❑ **Drop-arm**

❑ **Wheelchair**

❑ **standard** ❑ **lightweight**
❑ **ELR** ❑ **with low-pressure cushion**
❑ **power** ❑ **reclining**

❑ **Electric Hospital Bed**

❑ **Trapeze bar** ❑ **Alternating Pressure Mattress** ❑ **Alternating Pressure Pad** ❑ **Over Bed Table**

❑ **Folding Walker** ❑ **with wheels**

❑ **Canes** ❑ **Single point** ❑ **Quad**

❑ **Crutches** **Height:**

❑ **Patient Lift**

❑ **Suction Machine**

Comments

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