GRADY HEALTH SYSTEM
HOME HEALTH DEPARTMENT
FACE-TO-FACE DURABLE MEDICAL EQUIPMENT ORDER

PATIENT NAME:_____ AREA: _____
LAST FIRST
MRN:_____ BIRTH DATE: _____/_____/_____ SSN:_____/_____/_____

MEDICARE NUMBER:_____ MEDICAID NUMBER:_____ PRIVATE INSURANCE POLICY NUMBER:_____

HOME ADDRESS: _____

CITY:_____ STATE:_____ ZIP:_____ PHONE:_____

SOCIAL WORKER: _____ CONTACT#_____ PHYSICIAN: _____

ADMISSION DATE:_____/_____/_____ REFERRAL DATE:_____/_____/_____ DISCHARGE DATE:_____/_____/_____

DIAGNOSIS:_____ HEIGHT:_____ WEIGHT:_____

TYPE OF EQUIPMENT NEEDED:

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6)_____

LENGTH OF TIME NEEDED: _____ HAS PATIENT APPLIED FOR: MEDICAID?_____MEDICARE?_____

SSI?_____ CLINIC IN WHICH PATIENT IS TO BE FOLLOWED: _____

NAME OF RELATIVE NOT LIVING WITH PATIENT:_____

ADDRESS:_____ CITY: _____

STATE: _____ ZIP:_____ PHONE:_____ RELATIONSHIP: _____

IS EQUIPMENT TO BE DELIVERED TO PATIENT'S HOME? ___YES___NO IF NOT, PLEASE GIVE ADDRESS OF DELIVERY SITE:

NAME: _____ RELATIONSHIP: _____
HOME ADDRESS: _____
CITY: _____STATE:_____ZIP:_____ PHONE: _____

PLEASE NOTE BELOW ANY INFORMATION THAT MAY HELP IN PROCESSING THIS ORDER:

_____

_____

PHYSICIAN SIGNATURE: _____ PRIINTED_____DATE:_____

PHYSICIAN NPI: _____ PIC# _____

PATIENT SIGNATURE: _____ DATE: _____ (IF DELIVERED AT FACILITY)