HOMECARE DIMENSIONS

☐ New Referral

☐ Existing Patient Order(s)

Toll Free: 1.888.833.2323

Circle One Fax Number

512.973.9323	361.854.3915	214.000.0000	915.626.5045	682.708.3806	210.694.7800	956.627.0724
Austin	Corpus Christi	Dallas	El Paso	Fort Worth	San Antonio	RGV

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: _____

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
- ❑ Other _____

- ❑ Oxygen _____ O2 Sat@Room Air _____ LPM _____ Freq. _____
- ❑ **CPAP _____ Supplies _____
- ❑ **BiPAP: IPAP _____ EPAP _____ Supplies _____
- ❑ Powered Wheel Chairs
- ❑ Enteral Feeding: ❑ Pump ❑ Bowless
  Formula _____ cc x hrs _____ cans per 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: _____

Physician Name: _____ Clinic: _____

Phone _____ Fax: _____

Physician Signature: _____ NPI#: _____ Date: _____

Thank you for your referral! Homecare Dimensions, Inc.

FOR OFFICE USE ONLY: Patient ID#: _____ Order #: _____ Intake Specialist: _____