SAN ANTONIO
Phone: (210) 614-3804
Fax (210) 614-3805

HONDO
Phone: (830) 741-8171
Fax (830) 741-8178

PATIENT INFORMATION

Patient's Name:________________ Gender: ☐ male | ☐ female

Patient's Date of Birth: ____/____/____ Patient's Soc. Security #:________________ * Height:________ * Weight:________

Home Phone:________________ Work Phone:________________ Alternate/Cell Phone:________________

Patient's Street Address:________________ Apt./Ste.________ City:________________ State:________ Zip:________

Emergency Contact Name:________________ Phone:________________

INSURANCE INFORMATION

Primary Ins:________________ Policy #:________________ Group #:________________ Phone:________________

Secondary Ins:________________ Policy #:________________ Group #:________________ Phone:________________

Diagnosis:________________ Length of Need (months):________ Prognosis: ☐ Poor | ☐ Fair | ☐ Good

HOME MEDICAL EQUIPMENT

☐ Oxygen
- ________ Liters/min
- ________ Hours/day
- ________ Portable "E" Tank

☐ Overnight Pulse Oximetry
☐ Conserving Device
☐ CPAP
☐ BIPAP
☐ Nebulizer
☐ Suction Machine
☐ Tracheostomy Supplies
☐ Feeding Pump
☐ Formula
- ☐ Ensure
- ☐ Glucerna
- ☐ ________________
- ☐ ________________

☐ Hospital Bed
- ○ Low Air Loss Mattress
- ○ Gel Overlay
- ○ Trapeze Bar

☐ Hoyer Lift/Sling
☐ Wheelchair
- ○ Light-Weight
- ○ Cushion
- ○ Elevating Leg Rests

☐ Power Wheelchair
☐ Seat Belt
☐ Scooter
☐ Wheelchair Ramp

The PINK BOUTIQUE
A Division of Bexar Care Medical Equipment & Supplies

☐ Walker
- ○ Wheeled

☐ Rollator
☐ Cane
- ○ Single ○ Quad

☐ 3-1 Commode
☐ Elevated Toilet Seat
☐ Bath Chair
- ○ w/Back ○ w/o Back

☐ Tub Transfer Bench
☐ Rolling Shower Chair
☐ Glucometer
☐ Talking Glucometer
☐ Uplift Seat
☐ Lift Chair
☐ Lymphedema Pump
☐ Tens Unit
☐ Other:________________

Description	Quantity Needed
Silicone Breast Prosthesis (L8030)	________
Leisure Breast Prosthesis (L8020)	________
Mastectomy Bras (L8000)	________
Cranial Prosthesis (wig A9282)	________

Compression Garments

Upper Extremity (UE)		Lower Extremity (LE)
☐ sleeve	☐ 15-20 mmHg	☐ above Knee (AK)
☐ gauntlet	☐ 20-30 mmHg	☐ below Knee (BK)
☐ glove	☐ 30-40 mmHg	☐ Custom (made to order)

Physician's Name:________________ **Physician's Phone #:**________________

Address:________________ **NPI#:**________________

____
Physician's Signature

____
Date

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