Ordering Physician Preferred Method of Communication
Email: ______________________________________
Phone: ____________________________

Home Health, DME, and Home Infusion Intake Sheet

Phone: 844-215-4264 **Fax: 844-215-4265**

Eligibility Effective Date:	❑ Medicare	**Date of Referral:**
Health Plan ID #:	❑ Male	❑ Female
Patient Last Name:	**First Name:**	
Address:		
Phone #:	**DOB:**	**County:**
Allergies:	**Ht/Wt:**	**Diabetic:** ❑ Yes ❑ No
Emergency Contact:	**Phone #:**	
PCP:	**Phone #:**	
MD Ordering:	**Phone #:**	
Referral Person:	**Phone #:**	
❑ Hospital ❑ SNF	❑ MD Office	❑ Case Mgmt.
Patient Diagnosis:		**Code:**
Procedures Performed:		
Facility Name:	**Admit Date:**	**D/C Date:**

❑ **HHC – Home Health Request** **SOC:** ______________________

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❑ **INFUSION – Home Infusion Therapy Request**

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INTRAVENOUS ACCESS:

Last Dose Administered:	**Due Date/Time: (next dose)**
Delivery Address:	**No. # Units:**

❑ **DME – DME Request: (For Oxygen – Please include the oxygen prescription form)**

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(Physician Signature) (Date)

Integrated Home Care Services
3700 Commerce Parkway Miramar, FL 33025 | 844-215-4264