Confidence First Medical Supplies

316 E Manchester Blvd, Inglewood, CA 90301

P: (310) 330-7636 F: (310) 330-7635

DME REFERRAL FORM

Date:			Name of Facility:		
Referral Contact:			Phone #:		
PATIENT DEMOGRAPHICS:					
First Name:	Last Name:		M.I.	Phone:	
Street Address:		City:		State:	Zip:
DOB:	Sex: M F	Ht:	Wt:	Social Security #:	
Emergency Contact / Responsible Party:				Phone:	
Address:		Email Address:			
INSURANCE INFORMATION:					
Primary Insurance: ❑ Medicare ❑ Medicaid ❑ Other		Secondary Insurance: ❑ Medicare ❑ Medicaid ❑ Other			
Name:		Name:			
Address:		Address:			
Phone:		Phone:			
Policy #:	Group ID #:	Policy #:	Group ID #:		

DIAGNOSIS / ICD9 CODES			
1.	2.	3.	4.

EQUIPMENT / SUPPLIES NEEDED: (CHECK ITEMS)			
❑ Single Point Cane	❑ Motorized Wheelchair	❑ Lift Chair	❑ Bedside Commode
❑ Quad Cane S L	❑ Scooter	❑ Heat Therapy Pump	❑ Shower Chair
❑ Walker ❑ with Wheels	❑ Hospital Bed	❑ Diabetic Shoes	❑ Transfer Bench
❑ Rollator (walker w/wheels & seat)	❑ Patient Lift	❑ Diabetic Supplies	❑ Raised Toilet Seat
❑ Manual Wheelchair	❑ Trapeze Bar	❑ Back Brace	❑ Grab Bars
❑ Transport Wheelchair	❑ Gel Overlay	❑ Knee Brace	❑ Other
❑ Wheelchair Cushion	❑ Low Airloss Mattress–ulcer stage __	❑ TENS Unit	

PHYSICIANS DEMOGRAPHICS:			
Physician Name:		NPI #:	
Street Address:	City:	State:	Zip:
Contact:	Phone:	Fax:	

Name of Referring Physician or Healthcare Professional: _____

Physicians Signature: _____ **Date:** _____

(if not available, verbal order or prescription ok)

(Please fax to 310.330-7635)