



NAME OF FACILITY: _____

REFERRAL CONTACT: _____

PHONE #: _____

REFERRAL SHEET

Contacts - Office: (704) 846-7503; Frank at Cell (704) 579-7070; Ashley at Cell: (704) 907-7134; Chad at Cell: (704) 968-1575 FAX: (704) 846-7911

PATIENT'S NAME: _____ PHONE# _____

PATIENT'S HOME ADDRESS: _____

CITY, STATE, ZIP: _____ DATE OF BIRTH: _____

PATIENT'S HEIGHT: _____ WEIGHT: _____ SEX: M F

PRIMARY INSURANCE: _____ ID#: _____

SECONDARY INSURANCE: _____ ID#: _____

EMERGENCY CONTACT & PHONE #: _____

DIAGNOSIS: _____

EQUIPMENT NEEDED: (circle items)

- WALKER
- ROLLATOR (walker with wheels and seat)
- SINGLE POINT CANE
- BEDSIDE COMMODORE
- RAISED TOILET SEAT
- SHOWER SEAT (seat only)
- HOSPITAL BED
- PATIENT LIFT
- LOW AIRLOSS MATTRESS—stage of ulcers _____
- WHEELCHAIR
- TRANSPORT CHAIR
- ELEVATING LEG RESTS
- SCOOTER
- PULSE OXIMETRY STUDY
- CPAP/BiPAP & SUPPLIES**
- WALKER WITH WHEELS
- QUAD CANE - BASE SIZE: S L
- CRUTCHES
- DROP ARM COMMODORE
- SHOWER CHAIR (seat with back support)
- TRANSFER BENCH
- GEL OVERLAY
- TRAPEZE BAR
- LIGHTWEIGHT WHEELCHAIR
- WHEELCHAIR CUSHION
- POWER WHEELCHAIR
- NEBULIZER (need diagnosis & medications)
- OXYGEN (see section below)

** (please include both the Initial Sleep Study & the Titration Study)

For OXYGEN: please fill out this section:

O2 at _____ LPM continuous or nocturnal via nasal cannula. Pulse ox reading was _____ % on room air obtained on _____ (date), while (circle one) at: rest exertion/ ex- exercise sleeping by _____

Is patient mobile within their residence and thus require portable O2? YES NO

Name of Referring Physician: _____ Length of Need: _____

Physician's Signature: _____ Date: _____
(if not available, must have verbal order or doctor's order)

(Please fax to Carolina's Home Medical Equipment, Inc. at 704-846-7911, and call office to let them know to expect the faxed referral.)