TRAVISMEDICAL ALLUMED

A NATIONAL SEATING & MOBILITY Company

SUPPLY ORDER FORM

Referral Source Name:________________ Referral Source Contact:________________ Referral Source Phone:________________

Demographic Information

BOLDED ITEMS MUST BE ANSWERED IN ORDER FOR REFERRAL TO BE PROCESSED

Patient Name:________________________________

DOB: ________________________________

Patient/Contact Phone:________________________________

Patient Address:________________________________

Primary Care Physician:________________________________

Diagnosis:________________________________

_______-___________-___________

Contact Name : ________________________________

Height: ________________________________

Weight: ________________________________lbs

Primary Insurance:___________ ID: ________________

Secondary Insurance:_________ ID:________________

Urological Supplies (Please input quantity of all needed all supplies)

_____ Sterile/Closed System Catheter Kit, Size: ___fr._____in

_____ Intermittent/In & Out Catheter, Size:____ fr.______in

_____ Foley/Indwelling Catheter, Size:_____fr_________cc

_____ Lubricating Jelly: Sterile Packets____ Tube:_______

_____ External Cath, Size:______Latex or Silicone __________

_____ Leg Bag, Size:________________________________

_____ Bed Bag, Size:________________________________

_____ Existing Product #'s: ________________________

Enteral Supplies (Please input the quantity of all needed supplies)

_____ Ambulatory Feeding Pump

_____ Stationary Feeding Pump

_____ IV Pole

_____ Feeding Bags

_____ Gravity Bags

_____ Bolus Feeding Kits

_____ Gastrostomy Tube: ______fr_______cm

_____ Extension Sets: 12" 24"

_____ Syringes: 10cc 20cc 60c

_____ Enteral Nutrition:___________Calories/day:__________

# of cans/month Brand

_____ Existing Product #'s: ____________________ _____ Additional Notes:__________________________

Diabetic Supplies (Please input the quantity of all needed supplies)

_____ Glucometer (does client own one?

_____ Test Strips

_____ Lancets

_____ Uses Insulin?

_____ Does Client already own a glucometer? If so, what kind?

_____ Lancing Device

_____ Control Solution

_____ Alcohol Prep Pads

_____ Frequency if Testing

_____ Additional Notes: ____________________________

Incontinence Supplies (Please input the quantity of all needed supplies)

______ Diapers, Size:_______

______ Pullups, Size:_______

______ Undergarments

______ Wipes

______ Bladder Control Pads

______ Underpads

______ Moisture Barrier Cream

______ Gloves Size: ____

______ Additional Notes:____

☐ Client in Home Health Stay/Episode: Yes ☐ or No ☐

☐ OTHER DME/Supplies: ____

☐ Qty: ____

☐ Length of Need for Supplies: ____

Physician Signature: ______________________________ Date: ______________________________

** Additional paperwork will be required **

Email completed form to SSD.referrals@travismedical.com or Fax to (254) 773-1227.