BEXAR CARE

HOME MEDICAL EQUIPMENT & SUPPLIES

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
- □ 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:_____

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

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*** _____