



**Patient Information (Required for Scheduling)**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex:  M  F SS#: XXX-XX-\_\_\_\_\_  
First & Last Name

Patient's Address: \_\_\_\_\_  
Street City State Zip Code

Home Phone #: \_\_\_\_\_ Mobile Phone #: \_\_\_\_\_ Email Address: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Plan & Product

Secondary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Plan & Product

**Order Information - Breast Health Program**

Diagnosis:  Pre-Operative: surgery type: \_\_\_\_\_ Date: \_\_\_\_\_  
 Post-Operative: surgery type: \_\_\_\_\_ Date: \_\_\_\_\_  
 Lymphedema: \_\_\_\_\_  
 ADL Limitation/Decreased Functionality: \_\_\_\_\_  
 Other(s): \_\_\_\_\_

ICD-CM Diagnosis Codes for checked items above: \_\_\_\_\_

Evaluate and Treat Physical Therapy/Occupational Therapy

Prosthetic Bra:  Right  Left  Bilateral

Compression Garments (to include as appropriate): 2 sets Class I-II Compression Arm Sleeves, 2 sets Class I-II Compression Gloves, 2 Compression Bras, and Night Garments.

Special Instructions: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

***For Medicaid referrals we must be provided with date of onset, diagnosis and supporting clinical notes in order to obtain authorization to treat your patient.***

**Referring Physician Information**

Physician Name (first & last): \_\_\_\_\_ NPI#: \_\_\_\_\_ GA License #: \_\_\_\_\_  
 Physician Address: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_  
 I hereby certify that the services indicated in the above order form are medically necessary.  
 Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_