DeKalb Medical
Tax ID Number 58-1966795

PS-1055

Breast Health Program Order Form
N. Decatur - FAX orders to: 404.501.7186
Phone: 404.501.5140
Hillandale - FAX orders to: 404.501.8387
Phone: 404.501.8140

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:** _____