Shield HealthCare

615 Strander Boulevard | Tukwila, WA 98188
Phone: 800.720.7440 Fax: 206.575.6765

Fax Order Form

Please complete all of the following information. Incomplete information could result in a delay of your patient's order.

☐ New Order ☐ Re-order

PATIENT INFORMATION

Patient Name: ______________________
Address: ______________________
City/St./Zip: ______________________
Telephone #: ______________________
D.O.B. ____________
Start Date: ________ Length of need (99 = lifetime): ______
Diagnosis: ______________________
____

INSURANCE INFORMATION

☐ Medicaid ☐ Medicare ☐ Private Insurance
Policy #: ______________________
Group #: ______________________
Phone: ______________________
Secondary Insurance (if applicable): ______________
Policy #: ______________________
Group #: ______________________
Phone: ______________________

REFERRAL INFORMATION

Home Health/Hospital: ______________________
Telephone #: ______________________
Date Referral Faxed On: ______________________
Referral Faxed By: ______________________
Telephone #: ______________________ Ext. ________

PHYSICIAN INFORMATION

Physician Name: ______________________
Physician Telephone #: ______________________
Address: ______________________
City/St./Zip: ______________________

UROLOGICAL ORDER

PRODUCT DESCRIPTION	Quantity/Month	
☐ Insertion Trays		
☐ Irrigation Trays		
☐ Leg Bag, Disposable		
☐ Drainage Bags		
☐ Adhesive Remover		
☐ Lubricant		
☐ Foley Caths		Size: ______ CC: ______
☐ Intermittent Caths		Size: ______
☐ External Caths		☐S ☐M ☐L ☐XL

INCONTINENCE ORDER

PRODUCT DESCRIPTION	Quantity/Month
☐ Disposable Briefs/Diapers	
☐ Chux/Underpads	
☐ Liners/Pads/Shields	
☐ Undergarments	
☐ Other: ______________	
☐ Other: ______________	

ENTERAL NUTRITION ORDER

Feeding Formula (Brand): ______________________
Cans/month: ________

PRODUCT DESCRIPTION	Quantity/Month
☐ Enteral Pump	
☐ Feeding Bags Size: ________	
☐ Feeding Tubes Size: ________	
☐ Syringes, 60cc	
☐ Gauze, each	
☐ Gravity Feeding Bags	

Check Appropriate boxes:
☐ Sole Source Of Nutrition ☐ G or J Tube Placed
☐ Patient Will Be Fed For At Least 3 Months

OSTOMY ORDER

PRODUCT DESCRIPTION	Qty/Month	Item #
☐ Closed End Bags		
☐ Drainable Bags		
☐ Urinary Ostomy Bags		
☐ Wafers		
☐ Stoma Caps		
☐ Appliance Cleanser		
☐ Deodorizers		
☐ Paste		
☐ Powder		
☐ Tape		
☐ Other: ____________		
☐ Other: ____________		

PLEASE FAX COMPLETED FORM TO 206.575.6765

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