INCONTINENCE ORDER FORM

Galaxy Medical SUPPLY
291 Pennsylvania Ave
Brooklyn, NY 11207

P 718-708-7258
F 718-708-7259
E galaxymedicalsupply@gmail.com

REFFERED BY: _____ TITLE: _____ PHONE: _____
ORGANIZATION: _____ EMAIL: _____

PATIENT NAME: _____ M ☐ F ☐ OTHER ☐ PHONE: _____
ADDRESS: _____ DOB: _____
CITY: _____ ZIP: _____ HIGHT: _____ WEIGHT: _____

MEDICARE #: _____ MEDICAID #: _____
COMMERCIAL INS. NAME: _____ POLICY #: _____
SUPPORTING DIAGNOSIS: _____
ALLERGIES: _____

PHYSICIAN: _____ NPI #: _____ EMAIL: _____
ADDRESS: _____ PHONE: _____ FAX: _____

INCONTINENCE

- ☐ DIAPERS Size: _____
- ☐ BRIEFS Size: _____
- ☐ PULL-UPS Size: _____
- ☐ BLADDER CONTROL PADS/LINERS
- ☐ REUSABLE UNDERPADS
- ☐ DISPOSABLE CHUXS
- ☐ BARRIER CREAM
- ☐ GLOVES
- ☐ WIPES

Galaxy Medical SUPPLY

OTHER ITEMS PLEASE WRITE IN ANY ITEM YOU MAY NEED THAT IS NOT USED ON THIS FORM

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

X BY SIGNING THIS DOCUMENT I, THE PHYSICIAN NAMED ABOVE, AGREE THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND THE MEDICAL SUPPLIES/EQUIPMENT ARE MEDICALLY NECESSARY AND APPROPRIATE FOR THE PATIENT.

_____ _____
PHYSICIAN DATE