



**Home Medical Specialties, Inc.  
Equipment Order Form**

**Tel. NO. (718) 418-2000**

**Fax (718) 326-1400**

**FACILITY NAME**.....

**REFERRAL SOURCE**.....**PHONE**.....

**ORDER DATE**\_\_\_/\_\_\_/\_\_\_      **SEX**\_\_\_\_\_      **D.O.B.**\_\_\_/\_\_\_/\_\_\_

**INSURANCE #**\_\_\_\_\_ **SEQ.#**\_\_\_\_\_

**NAME OF INSURANCE**\_\_\_\_\_

**PATIENT NAME**\_\_\_\_\_

(PLEASE PRINT)

**ADDRESS**\_\_\_\_\_ **APT#**\_\_\_\_\_

**BOROUGH**\_\_\_\_\_ **ZIP**\_\_\_\_\_

**HOME PHONE #**\_\_\_\_\_ **DIAGNOSIS**\_\_\_\_\_

**NEBULIZER/COMPRESSOR SERIAL NUMBER**\_\_\_\_\_

**ATTENDING PHYSICIAN**\_\_\_\_\_ **LIC#**\_\_\_\_\_

**PLACE PRESCRIPTION**

**HERE**