Sherwood Clinical
DME Solutions
P: 800-847-3987 • F: 706-894-2808 • www.sherwoodclinical.com

Sherwood Clinical Home Enteral Formula Referral

Please complete the form below and Fax to 706-894-2808.
If you prefer, you may call 1-800-847-3987 with your referral
*** We will contact you for confirmation of received fax.***

PATIENT INFORMATION

Patient Last Name _____ First Name _____ (M __ / F__)
DOB: (MM/DD/YYYY) _____ Social Security # _____
Address _____
City _____ State _____ ZIP _____
Home Phone # (_____) _____ Cell # (_____) _____
Current Height _____ Weight _____ Allergies _____

INSURANCE INFORMATION

Please provide a current copy of insurance card(s) or complete the following information.

Primary Insurance _____ Policy # _____ Group # _____
Policy Holder's Name _____ DOB: (MM/DD/YYYY) _____ Insurance Co. Telephone # _____
Secondary Insurance _____ Policy # _____ Group # _____
Policy Holder's Name _____ DOB: (MM/DD/YYYY) _____ Insurance Co. Telephone # _____
PRIMARY DIAGNOSIS: _____ **ICD10 Code:** _____
FEEDING MODALITY: _____

FEEDING REGIMEN/ SUPPLIES	Start of Care	End date
1.		
2.		
3.		
NOTES:		

Home Health Agency: _____ **Phone #** _____

PHYSICIAN INFORMATION

Physician Name _____ NPI #: _____
GA License #: _____ UPIN #: _____ DEA #: _____
Address _____ City _____ State _____ ZIP _____
Phone # (_____) _____ Fax # (_____) _____ Office contact name _____ Ext _____

Please also include:

List of Discharge /Medications & Final Discharge Orders
History & Physical/ Recent Clinicals
Clinical Dietitian Note

Physician Signature: _____ Date _____
Office Contact Name: _____ Phone _____

Sherwood Clinical will verify all insurance benefits with the insurance company(s) listed above prior to administration. The patient will also be notified prior to administration of any out of pocket expenses or co-payments.

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