



P.O. Box 271195
Oklahoma City, OK 73137
o. 800-745-2215 | f. 866-399-9338
www.argencis.com

TRACHEOSTOMY SUPPLY ORDER FORM

TO ENSURE PROMPT DELIVERY, PLEASE FAX THIS FORM AND PATIENT FACESHEET TO 866-399-9338. RAPID PROCESSING AND NEXT DAY DELIVERY. GUARANTEED.

REFERRING ENTITY INFORMATION

PATIENT INFORMATION

FACILITY NAME: _____ PATIENT NAME: _____
CONTACT NAME: _____ D.O.B. : _____
CITY/STATE: _____ ADDRESS: _____
PHONE: _____ CITY/STATE: _____
FAX: _____ PHONE: _____

PHYSICIAN'S ORDER: TRACH CARE _____ AND PRN. SUCTION _____ AND PRN. CHANGE TRACH EVERY _____ MONTHS AND PRN. CHANGE INNER CANNULA _____ AND PRN.

DISCHARGING TO:

HOME HEALTH SKILLED FACILITY HOME HOSPICE LONG-TERM CARE OTHER: _____

PRODUCT INFORMATION:

BRAND: _____
TRACH ITEM #: _____
INNER CANNULA ITEM #: _____

SUCTION CATHETER INFORMATION: **SUCTION CATHETERS**

ARE NON-COVERED BY MEDICARE PART B. SOME COMMERCIAL PLANS AND STATE MEDICAID PROGRAMS PROVIDE LIMITED COVERAGE.

SUCTION CATH SIZE (IF APPLICABLE) #: _____

NOTES: _____

PHYSICIAN NAME: _____ TELEPHONE: _____

FORM COMPLETED BY: _____ TELEPHONE: _____
(Please Print)

SIGNATURE: _____ DATE: _____