PRAIRIE MEDICAL
1809 N. Lakes Place
Meridian, Idaho 83646
1-800-627-0617

Date: **Mastectomy New Patient Form**

Please print and complete this form, and do one of the following:

- Bring the form to your fitting appointment
- Mail the form at least one week prior to your appointment to Prairie Medical
- Fax the form before your upcoming appointment to **1-800-483-1656**

Name: _____ Phone: (_____) _____

Address: _____ City: _____ State: _____

Date of birth: ____/____/____ Appointment Date: ____/____/____

How did you hear about Prairie Medical: _____

Patient History

Have you had a mastectomy, partial mastectomy or lumpectomy? Yes /No

If YES, what type of surgery did you have (Circle): Unilateral Mastectomy Right/Left
Bilateral Mastectomy
Lumpectomy

If YES, when was your surgery? _____

If NO, when are you scheduled for surgery? _____

If YES, what was your bra size before surgery? _____

Do you have a history of any of the following (Circle all that apply):

Radiation Lymphedema

Chemotherapy Other Related Procedures: _____

Reason for Prairie Medical Appointment (Circle all that apply):

Pre-Op	Routine Fitting
Post-Op	Change in Condition
First Fitting After Surgery	New/Additional Surgery
Re-Fit	Replacement of Supplies
Pick-up Order	Lost Supplies
Other (Please describe):	

Referring Physician's Name: _____

Referring Physician's Phone Number: (____) _____

Insurance Information

Name of Insured: _____ Insured Person's Birthdate: ____/____/____

Name of Employer: _____

Address of Employer: _____

Name of Insurance Company: _____

Address of Insurance Company: _____

Policy Number: _____ Group Number: _____

Do you have a prescription for the products you are wanting to acquire? Yes/No

Have you received a breast prosthesis or mastectomy bra before? Yes/No When:

Have you received a post-surgical camisole or bra before? Yes/No When:

Was your insurance billed for any of the previous items you received? Yes/No

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To be completed by the patient AFTER the fitting:

I am satisfied with the fit and function of the products I received.	Yes	No
The fitter asked me if I have any questions.	Yes	No
My questions were answered satisfactorily.	Yes	No
I received written care instructions for the items I purchased.	Yes	No

Patient's Signature: _____ **Date: _____**

For Prairie Medical Fitter Only:

Have a copy of Medicare/Insurance Card?	Yes	No
Dispensing order on hand?	Yes	No
Detailed written order on hand?	Yes	No
Have clinical documents supporting continued use?	Yes	No
Continued medical need?	Yes	No

Prairie Medical Fitter's Signature: _____ **Date: _____**