Pretty in Pink boutique

DATE OF SERVICE: _____/_____/_____

CLINICAL INTAKE FORM

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Gender: F / M Date of Surgery: _____

Type of Surgery: Mastectomy Partial Mastectomy

Other (Please explain): _____

Surgery/Affected Side (circle one): Left / Right / Both

Lymph Node Removal? Yes No If Yes, how many nodes? _____

History of chemotherapy? Yes No

History of Radiation? Yes No

History of Lymphedema? Yes No

Treatment for Lymphedema? Yes No

If yes, please explain: _____Lymphedema Therapist_____

Objective Note: _____Bra Band Measurement: _____ Bra Cup Measurement_____

Is patient satisfied with this bra size? _____

Clinical Assessment: (note any visible scars, rashes, open wounds, etc)_____

_____

Specific Goals/Outcomes: _____

PRODUCT INFORMATION

Manufacturer	Style Number	Size	Color	Quantity

Product preference/dislikes notes: _____

Please initial the following:

- ☐ *Fitter reviewed care instructions with patient/caregiver?*
- ☐ *Fitter asked if there were any questions?*
- ☐ *Prices and Billing were discussed with the patient/caregiver?*

Follow Up Plan: _____

Fitter Signature: Date Signed:

TRAINING AND EDUCATION INFORMATION

Please initial the following:

- ☐ *Patient/Caregiver reviewed a copy of the privacy policies & the CMS Supplier Standards*
- ☐ *Patient/Caregiver received Use & Care Instructions, including Warranty Information, and understand the proper use, care, maintenance, and storage of the DMEPOS Product. Patient/Caregiver understands that they may call back with questions.*
- ☐ *Patient/Caregiver understand that there is a 14-day return policy on any items purchased.*
- ☐ *Patient/Caregiver received a copy of the Customer Satisfaction Survey.*
- ☐ *Patient/Caregiver was asked if they have any questions or concerns (specify): _____*
  Is follow up needed to answer Patient/Caregiver's questions or concerns? No Yes

Patient Signature: Date Signed:

Certified Fitter Reviewed: Date Reviewed: