



CLOCK MEDICAL SUPPLY, INC.
SOLVING PROBLEMS / DELIVERING SOLUTIONS

901 INDUSTRIAL BLVD
PHONE: 1-620-221-0550

PO BOX 620
TOLL FREE: 1-800-362-1314

WINFIELD, KS 67156-0620
FAX: 1-620-221-7460

FAX

To:

From:

Fax:

Pages: (including cover page)

Phone:

Date:

RE:

Patient DOB:

DIAPER / PULLUP ORDER

To Whom It May Concern:

Please review the following order and complete the information where the ➡ indicates

Also verify that all the information is correct or make corrections accordingly.

THANK YOU

Please complete the following:

Length of need

Date last seen by physician

Doctor Notes

Physician's Signature and Date

And FAX to 620-221-7460

Thank you for your time and help

HAVE A GREAT DAY!

IMPORTANT: This facsimile transmission contains confidential information, some or all of which may be protected health information as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule. This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient (or an employee or agent responsible for delivering this facsimile transmission to the intended recipient), you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by telephone (number listed above) to arrange the return or destruction of the information and all copies.

DIAPER / PULLUP ORDER



Solving Problems / Delivering Solutions

901 Industrial Blvd, PO Box 620
Winfield, KS 67156
Phone: 620-221-0550
Toll Free: 800-362-1314
Fax: 620-221-7460

Beneficiary Name: _____

Address: _____

City/ST/Zip: _____

DOB: _____

Start Date of Order: _____

Length of Order: _____

Clock # _____

Diagnosis: _____

 **Length of Need:** _____

Items to be dispensed:

☐



Diapers (6/day)

☐

Pullups (6/day)

Please select one

 **Date last seen by physician:** _____

 **Physician Signature:** _____ **Date:** _____ 

Physician's Name: _____ **Phone:** _____

Address: _____ **Fax #:** _____