DME

Physician Order/Prescription

800-540-7252

Referred by: Name____________________

Office____________________

Phone #____________________

Fax completed form with Physician's Signature to 888-651-6709

Patient Information

Patient Name: ____________________ Date of Birth: __________ Gender: M / F

Patient Phone #: __________ Alternate Contact: __________ Alternate Phone #: __________

Address: ____________________ City: __________ State: ____ Zip Code: ______

Medicare #: ____________________ Social Security #: ____________________

Medicaid #: ____________________ Secondary Insurance: ____________________

Wheelchair Base
__ Standard Weight
__ Light Weight
__ High str. Light weight
__ Pediatric wheelchair
__ Heavy Duty/ Bariatric
__ Recliner

Dimensions
__ 16"X16" __ 16"X18"
__ 18"X16" __ 18"X18"
__ 20"X16" __ 20"X18"
__ 22"X__" __ Other
__ 24"X __"
__ 10X 10 __ 10X 12

Front Riggings
__ Elevating Leg rests
__ Articulating Leg rests
__ Swing away foot rests
__ Angle adj. footplates
__ Heel Loops

Arm Rest Style
__ Fixed Ht. Full Length
__ Fixed Ht. Desk Length
__ Adjustable Ht. Full Length
__ Adjustable Ht. Desk Length

Wheelchair Options
__ Seat Belt
__ Anti-tippers (Front or Rear)
__ Wheel locks (Pull or Push)
__ Amputee Adapters
__ Stump Support (R or L)
__ Wheel lock extensions
__ Open Seat to Back Angle
__O2 Tank Holder
__Other__________________

Seat/Floor Height
__ Standard (19.5")
__ Hemi (17.5")
__ Super Hemi (15.5")
__ Super Low (13.5")
__ Tall (21.5") (9000XDT ONLY)

Walkers
__ Standard Ht.
__ Junior Ht. (Below 5'3")
__ Tall Ht.
__ Walklite Walker (w/seat)

Walker Options
__ 5" Straight Wheels
__ 5" Pivoting Wheels
__ 3" Straight Wheels
__ 3" Pivoting Wheels
__ Walker NO Wheels
__ Platform Attachment (R or L)

Canes
__ Standard Adjustable Cane
__ Offset Cane
__ Small Base Quad Cane
__ Large Base Quad Cane

Commodes
__ 3-in-1 Commode
__ Drop Arm Commode
__ Extra Wide Heavy Duty

Beds
__ Electric Hospital Bed
__ Bariatric Hospital Bed

Bed Options
__ Half Rails
__ Full Rails

Support Surfaces
__ Gel Overlay
__ Alt. Pressure Pad
__ Low Air-Loss Mattress

Incontinence
__Adult
Diaper or Pullup
__Pediatric
Diaper or Pullup

Urology
Catheter

Respiratory
__ Oxygen Concentrator
__ Portable O2 Tank
__ Home fill Unit
__ Liquid Oxygen
__ Nebulizer
__ Bi-Pap
__ C-Pap
__ Ventilator
__ Suction
__**Apnea Monitor**

___**Bili Blanket**

Prognosis__________________________ **Date last seen** ___/___/______

Wheelchair Cushion Type___General Use Cushion__Skin Protection Cushion_____Positioning Cushion:____Skin Protection/Positioning Cushion
Solid Seat Insert YES / NO
Wheelchair Back Type/ Model___General Use Back___Positioning / Posterior Back___Positioning / Posterior-Lateral Back

___ Deliver to facility room ___ Deliver to patient's home

DIAGNOSIS CODE/DESC (ICD): ____________________
DIAGNOSIS CODE/DESC (ICD): ____________________

EST. LENGTH OF NEED (# OF MONTHS): _____ 1-99 (99=LIFETIME)

*****OXYGEN – WE MUST HAVE LITERS PER MINUTE & SATURATION TAKEN ON ROOM AIR: Sat ORA:___ L/M:____ Via: Mask or Canula**

Physician Information

Physician's Name: ____________________ Phone #: ____________________

Address: ____________________ City: __________ State: ______ Zip: __________

NPI #: ____________________ License #: ____________________

Physician's Signature ______________________________ **Date** _____/_____/_____
MM DD YY

By my signature above, I confirm that the patient has the medical condition(s) listed and is being treated by me. All the information set forth in this Physician's Order accurately reflects the patient's medical condition(s) and the treatment regimen that I have prescribed. The patient's wounds are evaluated on a monthly basis unless otherwise documented in the medical record.
The patient/caregiver is able to use the prescribed supplies. My office has informed the patient that this order has been submitted to a DME supplier on behalf of the patient.

Approved By

www.medirents.net