



STANDARD WRITTEN ORDER

Please include
Face Sheet & Diagnosis
Fax: 216-252-4930

Order Date: ____/____/____

Patient Name _____

Policy # _____

Insurance _____

Address _____

City/Zip Code _____ **Height _____ **Weight _____

Discharge Date/Time _____

Phone _____

Date of Birth _____

Length of Need (99=lifetime) _____

Deliver equipment to: Patient home Facility / Room #

<p>Hospital Bed</p> <p><input type="checkbox"/> Semi-Electric (up to 350lbs.) <input type="checkbox"/> Heavy Duty (over 350 lbs.) <input type="checkbox"/> Ex. Heavy Duty (over 650 lbs.)</p> <p>Bed Accessories</p> <p><input type="checkbox"/> Full Rails (2ea) <input type="checkbox"/> Half Rails (2ea) <input type="checkbox"/> Trapeze Bar <input type="checkbox"/> Hoyer Lift with Sling <input type="checkbox"/> Sling with commode opening <input type="checkbox"/> Sling – Specify Below: _____</p> <p>Support Surfaces</p> <p><input type="checkbox"/> Alt Press Pad and Pump <input type="checkbox"/> Foam/Gel Overlay <input type="checkbox"/> Low Air Loss/Alt Pressure</p>	<p>Aids to Daily Living</p> <p><input type="checkbox"/> 3 in 1 Commode <input type="checkbox"/> Heavy Duty Commode <input type="checkbox"/> Drop Arm Commode <input type="checkbox"/> HD Drop Arm Commode <input type="checkbox"/> Transfer Bench <input type="checkbox"/> Shower Chair (back / no back) <input type="checkbox"/> Raised Toilet Seat</p>	<p>Wheelchair</p> <p><input type="checkbox"/> Standard <input type="checkbox"/> Light Weight <input type="checkbox"/> High Strength Lt. Wt. <input type="checkbox"/> Heavy Duty <input type="checkbox"/> Hemi STF Height (17") Width: <input type="checkbox"/> 16 <input type="checkbox"/> 18 <input type="checkbox"/> 20 <input type="checkbox"/> 22 Depth: <input type="checkbox"/> 16 <input type="checkbox"/> 18 <input type="checkbox"/> Arm Trough <input type="checkbox"/> Stump Support</p> <p>Wheelchair Accessories</p> <p><input type="checkbox"/> Footrest (2ea) <input type="checkbox"/> Elev. Legs (2ea) <input type="checkbox"/> 3" Foam Cushion <input type="checkbox"/> General Use back <input type="checkbox"/> Full Arms (2ea) <input type="checkbox"/> Desk Arms (2ea) <input type="checkbox"/> Reclining Back <input type="checkbox"/> Seat Belt <input type="checkbox"/> Anti-Tippers (2ea) <input type="checkbox"/> Wheel Lock Extensions (2ea) <input type="checkbox"/> Transfer Board</p>
<p>CPAP/BiPAP</p> <p><input type="checkbox"/> CPAP: _____ cm H₂O (4-20) <input type="checkbox"/> AutoPAP: _____ to _____ cm H₂O <input type="checkbox"/> BiPAP: I _____/E _____ cm H₂O Res Rate: _____ <input type="checkbox"/> Mask to fit (1/3 month) OR Mask Type: _____ <input type="checkbox"/> Headgear (1/6 month) <input type="checkbox"/> Heated Humidifier (1/6 month) <input type="checkbox"/> Tubing (1/3 month) <input type="checkbox"/> Heated Tubing (1/3 month) <input type="checkbox"/> Disposable Filter (2/month) <input type="checkbox"/> Reusable Filter (1/3month)</p>	<p>Oxygen</p> <p><input type="checkbox"/> Oxygen LPM _____ Via: _____ <input type="checkbox"/> Rest <input type="checkbox"/> Exertion <input type="checkbox"/> Nocturnal <input type="checkbox"/> Continuous <input type="checkbox"/> Concentrator <input type="checkbox"/> Portable Gas <input type="checkbox"/> Evaluate for & Dispense O₂ Conserving Device <i>If O₂ Sat is maintained at _____% during evaluation.</i></p>	<p>Nebulizer</p> <p><input type="checkbox"/> Nebulizer (1/5 years) <input type="checkbox"/> Admin Set (2/month) <input type="checkbox"/> Mask (2/month)</p>
<p>Medicaid, Medicare and Medicare HMO plans require a face to face exam prior to ordering and dispensing DME. Please include chart notes, proof of face to face exam, face sheet, insurance information and diagnosis list with every order.</p>		

Physician Name (Print) _____

Phone Number _____

Signature _____

Date _____

NPI _____

Would you like a phone call verifying receipt of this fax: YES NO

Referral Contact Name _____ Facility _____

Contact Number _____ Contact Fax _____