Detailed Written Order for Home Medical Equipment

Patient: ________________________________________ DOB: _______________ DX: ____________________

1 – Concentrator And Portable Home O2: Via Nasal Cannula @ _____ Liters LON:____
Select One: ___Continuous ___On Exertion ___Nocturnal

1 – Nebulizer Machine: LON:____
Select all that apply: ___Nebulizer Mask (1/Mth) ___Disposable Nebulizer Kit (2/Mth) ___Non-Disposable Nebulizer Kit (1/6mths) Refills: ____
Medication: ____________________________ Strength: _____ mg/mL Total # of Vials per Month: ______
Freq: _____ Vial Every _____ Hours Refills: _____

1 – Suction Machine: LON:____
Select all that apply: ___ Suction Tubing (1/Mth) ___ Suction Canister (15/Mth) ___Yanker (12/Mth) ___ Trach Suction Catheters (90/Mth) Refills: ____

Trach Supplies: ___Trach Inner Cannula (60/Mth) ___Trach Collar (30/Mth) ___Trach Mask (1/Mth) ___Trach Care Kit (31/Mth) ___Trach Cuffed/Non-cuffed Tube (1/Mth) ___Trach Plug (1) ___ Sterile H2O: 500mL X ____ LON: _____ Refills: ____

Diabetic Supplies: (Indicate # of boxes ordered per month) ____Lancets (100/Box) ____Test Strips (50/Box) Testing Frequency: Check BS ____ Times Per Day Select One: IDDM / NIDDM LON: ____ Refills: ______

1 – Cane: ___Straight Cane ___Quad Cane LON: ______

1 – Walker: ____Folding Walker ____HD Folding Walker (>250#) ____Rolling Walker ____HD Rolling Walker (>250#) ____Rolling Walker w/ Seat ____HD Rolling Walker w/ Seat (>250#) LON: ______

1 – Wheelchair w/ Foot Rests & Anti-Tippers: ___Standard ___Lightweight ___ Heavy Duty(250-300#) ___ Extra Heavy Duty(>300#) LON: ______

Elevating Leg Rests: ___ Left (1) ___ Right (1) ___ Bilaterally (2) LON: ______

1 – Wheelchair Cushion: ___ General Use Back Cushion ___General Use Seat Cushion ___ Gel-Skin Protecting Cushion LON: ______

1 – Semi-Electric Hospital Bed With Standard Mattress: ___ Standard ___ Heavy Duty (350-600#) ___ Extra Heavy Duty (>600#) LON: ______

1 – Support Surface: (Select) ___ Gel Overlay ___ Alternate Pressure Pad ___ Low Air Loss Mattress LON: ______

1 – Bedside Commode: ___Standard ___Heavy Duty (>300#) LON: ______

1 – Drop Arm Bedside Commode: ___Standard ___Heavy Duty (>300#) LON: ______

Enteral Nutrition: ____________________________ Qt: ___ Syringes ___ Gravity Sets ___ Pump Sets Frequency: _____ (cans per day) Total Qt Ordered: _____ (cans)
___Enteral Pump (1) with IV Pole (1) Settings: _______ mL / Hour X ___ Hrs Flush: _______ mL Every _______ hr Refills: ____ LON: ______

Urinary Catheters: Qty per Month: _____ Refills: _____ LON: ____ Frequency of Use: _____ Times Per Day Select Type: ___Indwelling ___Intermittent ___Coude ___External Size: ____ French

Other: ___________________________________________ Qty: _____ LON: ______

Provider Name: __________________________________________ NPI: __________________
Provider Signature: _________________________________________ Date: ____________________

***Chart Notes Must Be Forwarded with Form to Support Medical Necessity***