DURABLE MEDICAL EQUIPMENT ORDER FORM

PATIENT INFORMATION

Patient Name:_____ Estimated Length of Need:_____

Patient DOB:_____ Date of Face to Face Assessment:_____

Start Date:_____ Height:_____ Weight:_____

DIAGNOSIS

Oxygen	Nebulizer	Hospital Bed	Ambulatory	CPAP/BiPAP
☐COPD J44.9	☐COPD J44.9	☐CHF I50.9	☐COPD J44.9	☐OSA G47.33
☐CHF I50.9	☐Bronchitis J40	☐COPD J44.9	☐Weakness M62.81	☐CSA G47.31
☐Cystic Fibrosis E84.0	☐Asthma J45.20	☐CVA I63.50	☐Difficulty Walking R26.2	
☐Lung Cancer C34.90	☐Pneumonia J18.8	☐CAD I25.10		
☐Pulmonary Fibrosis J84.10				
☐Emphysema J43.9				
☐Chronic Pulmonary Edema J81.1				
☐ Chronic Respiratory Failure J96.11				
☐Other:_____				

RESPIRATORY EQUIPMENT

☐Oxygen Concentrator or Other:_____ LPM:_____ Hours/Day:_____ Via: ☐ Nasal Cannula or ☐ Mask

☐Oxygen Gaseous Portable System ☐ Conserving Device ☐ Nocturnal Use Only ☐ Bleed In PAP

☐Portable Oxygen Concentrator (E1390+E1392 Billable Approved) LPM:_____ Hours/Day:_____ Via Nasal Cannula

☐CPAP w/ Humidifier and Supplies OR ☐BiPAP w/ Humidifier w/o Back Up Rate and Supplies OR ☐BiPAP w/ Back Up Rate w/ Humidifier and Supplies Settings:_____cmH2O

☐Nebulizer Compressor w/ Reusable Admin Set OR Mask OR Other:_____

☐Medication & Dosage:_____ ☐ QID ☐BID OR Other:_____

AMBULATORY AIDS

☐Walker (Folding)	☐Walker (Heavy Duty w/ Brakes)	☐Crutches (Self Pay)	☐Hemi Walker
☐Walker (Folding w/ Wheels)	☐Walker (Heavy Duty)	☐Cane (Self Pay)	☐Platform Attachment
☐Walker (4 Wheel w/ Seat)	☐Bedside Commode (Self Pay)	☐Quad Cane (Self Pay)	

HOSPITAL BED & ACCESSORIES (Unassigned Only)

☐Semi Electric Bed OR Other:_____ ☐Patient Lift

☐Trapeze ☐Pressure Reducing Mattress

Specific Type:_____

PULSE OXIMETRY

☐Multi Positional Pulse Oximetry ☐Overnight Pulse Oximetry

OTHER

☐Specify:_____

PHYSICIAN INFORMATION

Printed Name:_____ NPI:_____

Physician Signature:_____ Date:_____

FAX COMPLETED FORM AND PROGRESS NOTES TO

(772) 223-2824

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