THE MED MART CORPORATION

## DME/RESPIRATORY/ENTERAL SERVICES

## PH – 210-697-9933 FAX – 210-697-8753

Date: _____

### PATIENT INFORMATION

| NAME | PHONE | SS# | DOB | SEX |
|---|---|---|---|---|
| | | | | |
| **STREET** | **CITY** | **STATE** | **ZIP** | **HT/WT** |
| | | | | |
| **PRIMARY INS** | **POLICY #** | **GRP#** | **INSURED'S NAME** | |
| | | | | |
| **SECONDARY INS** | **POLICY #** | **GRP#** | **INSURED'S NAME** | |
| | | | | |
| **PHYSICIAN** | **NPI** | **DIAGNOSIS** | | |
| | | | | |
| **SPECIAL INSTRUCTIONS** | | **PROGNOSIS** | | |
| | | | | |

### MEDICAL EQUIPMENT

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ❒ | ALTERNATING PRESSURE PAD | ❒ | HOSPITAL BED | ❒ | WALKER WITH SEAT | | |
| ❒ | BEDSIDE COMMODE | ❒ | LOW AIR LOSS MATTRESS | ❒ | WALKER WITH WHEELS | ❒ | OTHER _____ |
| ❒ | CANE – QUAD | ❒ | PATIENT LIFT WITH SLING | ❒ | SHOWER CHAIR | | _____ |
| ❒ | CANE – SINGLE POINT | ❒ | SUCTION MACHINE | ❒ | WHEELCHAIR – STD | | _____ |
| ❒ | CRUTCHES | ❒ | TRAPEZE BAR | ❒ | W/C SEAT CUSION | | _____ |
| ❒ | GEL OVERLAY | ❒ | WALKER (NO WHEELS) | ❒ | W/C BACK CUSHION | | Length of Need: _____ {99 = Lifetime} |

### OXYGEN

| | | | | | | |
|---|---|---|---|---|---|---|
| ❒ | O2 _____LPM _____ | O2 SATS _____ | | DATE OF SATS _____ | | Length of Need: _____ {99 = Lifetime} |
| ❒ | CONCENTRATOR | ❒ | CONTINUOUS USE | MODE OF DELIVERY | | |
| ❒ | E CYLINDERS | ❒ | ON EXERTION | ❒ | CANNULA | |
| ❒ | M6 CYLINDERS & CONSERVER | ❒ | HOURS OF SLEEP | ❒ | BLEED IN | |

### ENTERAL NUTRITION

| | | | | | |
|---|---|---|---|---|---|
| ❒ | FORMULA: _____ | ❒ | PUMP | CC/HR: _____ | Length of Need: _____ {99 = Lifetime} |
| | | ❒ | BOLUS | CANS/DAY: _____ | |
| ❒ | FEEDING EXTENTSION SETS | ❒ | GRAVITY | CANS/DAY: _____ | |

### NEBULIZER

| | | | | |
|---|---|---|---|---|
| ❒ | ADULT | ❒ | PEDIATRIC | Length of Need: _____ {99 = Lifetime} |
| ❒ | KITS | ❒ | MASK | |

### INCONTINENCE

| | | | | | | |
|---|---|---|---|---|---|---|
| ❒ | Briefs/diapers | ❒ | Disposable Liner(Kotex) | ❒ | Disposable Underpads | Length of Need: _____ {99 = Lifetime} |
| ❒ | Pull-Ons | ❒ | Bed Liner | ❒ | Other _____ | |

I give permission to Med Mart to act as my agent/representative in transmitting this written prescription via fax to the provider of the patient's choice.

_____ Physician's Signature

_____ Date