DME Plan of Care & Instruction/Delivery

Name:	Date of Visit:
DOB:	☐ Initial Delivery or ☐ Follow-up

HOME ENVIRONMENT/SAFETY ASSESSMENT ☐ **NA – NOT DELIVERED TO HOME**

Discuss all appropriate factors and √ if in order ☐ **SAFETY** Uncluttered pathways — Fire safety assessed Safe operating equip — Cords & Adapters Safe environment — Pt/CG understands safety issues Bathroom assessed — Safe electrical outlet Area Rugs — Getting in & out of device Other:_____	**APPROPRIATE FOR HOME:** ☐YES ☐NO ☐ Alert & Understands INSTRUCTIONS ☐ Return Demonstration by patient ☐Confused/ caregiver instructed Personal/Physical limit _____ _____
HOME CARE SERVICE PROVIDER: (if applicable)	**Phone:**

EQUIPMENT

Device(s):	**Serial Number(s):**
1.	
2.	
3.	

√ TYPE OF PRODUCT

☐ Ambulatory products	☐ Manual Wheelchair	☐ Patient Handling Products
☐ Bath & Safety Products	☐ Power Wheelchair	☐ Transfer Aids
☐ Beds/Patient Room Products	☐ Orthopedic	☐ Ostomy/Urostomy/Catheter
☐ Seating Products	☐ Diabetic Supplies	☐ Compression Garment
☐ Scooter		☐ Other_____

ADDITIONAL INSTRUCTIONS

The following has been given and discussed to the patient/caregiver:

❑ Rights & Responsibilities	❑ Cleaning & Maintenance of equipment	❑ AOB signature
❑ Service availability of company	❑ Capped Rental/Purchase Letter	❑ Equipment Instructions
❑ Privacy Notice	❑ Complaint process (how it is reviewed /resolved)	
❑ Medicare Supplier Standards	❑ Warranty Information	❑ Return Demonstration

ADDITIONAL NOTES

FOLLOW UP/DISCHARGE

FOLLOW-UP VISIT RECOMMENDED ☐ FOLLOW-UP BY PHONE & AS NEEDED ☐

I have read, received and/or been instructed in detail on the items checked above.

(*If Patient unable to sign; authorized person complete*)

PATIENT SIGNATURE:	Print name/Relationship/WHY the patient can't sign:
EMPLOYEE'S INITIALS:	Signature:
IF THE AUTHORIZED REP DOES NOT LIVE WITH THE PATIENT, LIST THEIR ADDRESS/PHONE NUMBER	

Any customer complaints or unresolved problems should be reported to the Compliance Officer at 479-649-9500.