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**	**APPROPRIATE FOR HOME:** ☐YES ☐NO
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: ____________________	☐ Alert & Understands INSTRUCTIONS ☐ Return Demonstration by patient ☐ Confused/Caregiver instructed Note any Personal/Physical limitations: ____________________ ____________________
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)	☐ Info Brochure
☐ 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)

Patients Signature:	Printed name/Relationship/WHY the patient can't sign:
Employees Initials:	Signature:
IF THE AUTHORIZED REP DOES NOT LIVE WITH THE PATIENT, LIST THEIR ADDRESS/PHONE NUMBER →	