DURABLE MEDICAL EQUIPMENT DETAILED WRITTEN ORDER

START DATE:_______________

PATIENT____ **DOB:**_____________ **Weight:**_____lbs **Height:**______

Diagnosis:____

Length of Need: ☐99=Lifetime OR ☐______Months **# Refills:**________ **Frequency of Use:** ☐QD ☐BID ☐TID ☐QID

Quantity: 1 each or 1 pair unless otherwise noted in (parenthesis) next to description.

BEDSIDE COMMODE: ☐Standard(<300lbs) ☐Drop Arm ☐Heavy Duty (300lb+)

CANE: ☐Straight ☐Quad Small Base ☐Quad Large Base

CATHETER: ☐Foley(2/mth) ☐Intermittent #_____/mth Size: _____Fr ☐Condom(30/mth) ☐Leg Bag(2/mth) ☐Drainage Bag(2/mth)

COMPRESSION HOSIERY: ☐8-15mmHg ☐15-20mmHg ☐20-30mmHg ☐30-40mmHg ☐Thigh High **or** ☐Knee Length

CPM: ☐Knee Date of TKA Sx:_____________ Date CPM usage started: ________________

CRUTCH: ☐Axillary ☐Forearm / Lofstrand ☐Knee Walker

ENTERAL NUTRITION: Formula_____________________________________Route: ☐NG ☐PEG ☐ G/J Tube

Method: ☐Bolus/Syringe or ☐Gravity ____Cans ____x Per day ________Total Calories Per Day

☐Pump: Rate_______cc/ml per hour ______hours/day Flush: _____mL every _____ Hours

HOSPITAL BED: ☐Semi-electric ☐Full-electric ☐Heavy Duty (301lbs +) ☐Very Heavy Duty (601lbs+)

HOSPITAL BED MATTRESS: ☐Dry Pressure Prev. ☐Gel Overlay ☐Alt Pres. Pad & Pump ☐Low Air-Loss ☐Standard Foam

NEBULIZER: ☐ Medication Used: ___________________________Frequency ________ **Covered Dx Codes 491-505 Only**

OXYGEN: ☐Stationary Home Oxygen Concentrator **Set Liter Flow = _________** L/Per Min. via ☐Nasal Cannula 24/7

☐Portable Gaseous O2 Cont. Flow ☐Portable Gaseous O2 With Pulse Dose Flow/Conserver ☐Homefill System

☐Portable Oxygen Concentrator >>> Set **RATE at:** ☐2 LPM Continuous or ☐Pulse Dose

O2 Saturation: 1.) ______% on ROOM AIR at REST taken on _______________ (if Sat <or= 88 no additional testing required)

If #1 is > or = to 89 DO TEST# 2 & 3. 2.) ______% during exercise WITHOUT oxygen. (only required if % for test#1 on Room Air > 88%)

3.) ______% during exercise WITH oxygen applied (Must show hypoxia improvement to qualify).

>>> A SEPARATE clinical note documenting the O2 Sats recorded hereon & documentation of severe lung disease or hypoxia related symptoms expected to improve with O2 MUST SUPPLEMENT this DWO (Detailed Written Order) to be accepted by insurance.

PAP SUPPLIES: Mask: ☐Nasal(1 q3m) ☐Full Face(1 q3m) ☐Patient Choice(1 q3m) ☐Nasal Pillow(1 qmt) ☐Headgear(1 q6m) ☐Chin Strap(1 q6m) ☐Tubing (1 q3m) ☐Heated Tubing(1 q3m) ☐Rpmt Cushions (1 q3m) ☐Filters Disposable(2/mth) ☐Filters Reusable(2/mth)

PATIENT LIFT: ☐Standard Sling ☐Commode Cutout Sling ☐Divided Leg Sling

SUCTION: ☐Respiratory Pump ☐Yankauer ☐Tubing ☐Trach Cath(90/mth) ☐Oropharyngeal Cath(15/mth) ☐Trach Kit(30/mth)

TRAPEZE BAR: ☐Standard (<=250lbs) ☐Heavy Duty Freestanding(>250lbs)

WALKER: ☐Wheeled ☐No Wheels ☐Heavy Duty ☐With Seat ☐Plat. Attach: LT RT Both ☐Hemi /Side

WHEELCHAIR: ☐Lightweight(<300LBS) ☐Heavy Duty(250–300LBS) ☐Very HD(301+ LBS) ☐Standard ☐Tilt ☐Ultra-lightweight ☐Power

WHEELCHAIR CUSHION: ☐General Use/Comfort ☐Skin Protection ☐ Combo Skin Protection & Positioning ☐None

WHEELCHAIR BACK: ☐General Use/Comfort ☐Positioning ☐Sling ☐Reclining

WHEELCHAIR ARM TYPE: ☐Removable Adjustable Height Flip Back ☐Fixed Height

WHEELCHAIR ACCESSORIES: ☐Anti-Tippers ☐Wheel Lock Extension Handles ☐Pelvic Belt ☐Transfer Board ☐Headrest

WHEELCHAIR LE SUPPORT: ☐Swing-Away Footrest w/Heel Loops ☐Elevating Legrest (LE Edema or Knee Flexion>90°)__Lt __Rt

☐Amputee Stump Support with Swing-Away Hardware Side: ☐Left ☐Right ☐Omit LE support

WHEELCHAIR UE SUPPORT: ☐Arm Trough (Quad/Hemi-Plegic) ☐Hemi UE Support Tray

OTHER (Describe): ____Qty:________

CLINICIAN SIGNATURE: _____________________________________ **DATE:** ___________________________

Printed Name: ____ **Title:**_________**NPI:**_____________________

Fax completed form to 888-814-6917