

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