Detailed Written Order for Home Medical Equipment

Patient: _____DOB:_____ ICD-10: _____ Hgt:____ Wgt:____

❑ 1 – **Stationary Oxygen Concentrator And Portable Gaseous Oxygen System/Contents:**
Via ___ CPAP Mask ___Simple Mask ___Trach Mask
_____ Nasal Cannula @ _____ LPM **LON:____**
Select One: ___Continuous ___On Exertion ___Nocturnal
___Conserving device for pulse dose add acceptable liter flow for conserving _____ LPM

❑ 1 – **Nebulizer with Compressor: LON:_____**
Select all that apply: ___Nebulizer Mask (1/Mth)
___Non-Disposable Nebulizer Kit (1/6mths) Refills: ____

❑ 1 – **Suction Machine: LON:____**
Select all that apply: ___ Suction Tubing (1/Mth) ___ Suction Canister (15/Mth)
___ Yanker(Oropharyngeal suction catheter) (12/Mth) ___ Trach Suction Catheters (90/Mth) Refills: ____

❑ 1 – **Cane:** ___Straight Cane ___Quad Cane

❑ 1 – **Walker:** ___Folding Walker no wheels ___HD Folding Walker no wheels (>300#) ___2 Front Wheeled Walker
___HD 2 Wheeled Walker (>300#) ___4 Wheeled Walker w/ Seat ___HD 4 Wheeled Walker w/ Seat (>300#) ___Upright Walker

❑ 1 – **Wheelchair w/ Foot Rests & Anti-Tippers:** ___Standard ___Lightweight ___ Heavy Duty*(250-300#)*
___ Extra Heavy Duty*(>300#)* ____Reclining Back ___ Elevating Leg Rests (Bilateral) ____Transfer Board **LON: _____**

❑ 1 – **Wheelchair Cushion:** ___ General Use Back Cushion ___General Use Seat Cushion
___ Gel-Skin Protecting Cushion (___ Back/ ___ Seat) ____ Positioning Cushion (___ Back/ ___ Seat)

❑ 1 – **Semi-Electric Hospital Bed With Standard Mattress:** ___ Standard ___ Heavy Duty *(350-600#)*
___ Extra Heavy Duty *(>600#)* ____ trapezebar

❑ 1 – **Patient/Hoyer Lift**

❑ 1 – **Support Surface:** (Select) ___ Gel Overlay ___ Alternating Air Pressure Pad
____ Low Air Loss Mattress

❑ 1 – **Bedside Commode:** ___Standard ___Heavy Duty *(>300#)*

❑ 1 – **Drop Arm Bedside Commode:** ___Standard ___Heavy Duty *(>300#)*

❑ **Enteral Nutrition**: _____ Check One: ___Syringes (30/mth) ___Gravity Sets (30/mth) ___ Pump Sets (30/mth)
Frequency: _____(cans per day) Total Qty Ordered: _____(cans/month)
___Enteral Pump (1) with IV Pole (1)Settings: _____ mL / Hour X ___ Hrs Flush: _____ mL Every _____hr
Refills: _____ **LON: _____**

❑ **Urinary Catheters:** Qty per Month: _____ Refills: _____ **LON: ____** Frequency of Use: _____ Times Per Day
Select Type: ___Indwelling ___Intermittent ___Coude ___External Size: ____ French ___ Leg Bags (2/mth) ___Bed Bag (2/mth)
Change every other week

❑ 1 or 2 **Cam Boot** - ___Tall ___Short ___Left ___Right ___Pneumatic ___Non Pneumatic

❑ **Other:** _____ Qty: _____ LON: ____
Provider Name:_____ NPI:_____
Provider Signature:_____Date:_____

******Chart Notes Must Be Forwarded with Form to Support Medical Necessity******