Commode - Medicare Questionnaire

DETAILED WRITTEN ORDER FOR DURABLE MEDICAL EQUIPMENT

Prescriber's Name (Print) _____ ***NPI*** _____
REQUIRED *REQUIRED*

Order Date _____
REQUIRED

Prescriber's Signature X _____ ***Signature Date*** _____
STAMPED SIGNATURE NOT ACCEPTED *REQUIRED*

Please sign, date and fax back to Forester Family Medical Supply.

PATIENT INFORMATION

Patient Name _____ ***DOB*** _____

Phone#: _____ ***Height:*** _____ ***WT:*** _____

DURABLE MEDICAL EQUIPMENT

Please anser the 3 quesitons and send and additioanl chart notes.

1) Is the patient confined to a single room in the house?

☐ Yes ☐ No

2) IS the patient confined to one level of the house enviroment with no access to a toilet on that level?

☐ Yes ☐ No

2) Is the patient confined to the hoase and these are no toilet facilities in the house?

☐ Yes ☐ No

Any additional information: _____

_____

_____

_____

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