Detailed Written Order for Home Medical Equipment

Patient: _____ DOB: _____ DX: _____

o 1 – Concentrator And Portable Home O_2: Via Nasal Cannula @ _____ Liters **LON:____**
Select One: ___Continuous ___On Exertion ___Nocturnal

o 1 – Nebulizer Machine: **LON:_____**
Select all that apply: ___Nebulizer Mask (1/Mth) ___Disposable Nebulizer Kit (2/Mth)
___Non-Disposable Nebulizer Kit (1/6mths) Refills: ____
Medication: _____ Strength: _____ mg/mL Total # of Vials per Month: _____
Freq: _____ Vial Every ____ Hours Refills: _____

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

o Trach Supplies: ___ Trach Inner Cannula (60/Mth) ___Trach Collar (30/Mth) ___Trach Mask (1/Mth)
___Trach Care Kit (31/Mth) ___Trach Cuffed/Non-cuffed Tube (1/Mth) ___Trach Plug (1)
___ Sterile H20: 500mL X ___ **LON: ____** Refills: ____

o Diabetic Supplies: *(Indicate # of boxes ordered per month)* ____Lancets (100/Box) ___ Test Strips (50/Box)
Testing Frequency: Check BS ____ Times Per Day Select One: IDDM / NIDDM **LON: ____** Refills: _____

o 1 – Cane: ___Straight Cane ___Quad Cane **LON: _____**

o 1 – Walker: ___Folding Walker ___HD Folding Walker (>250#) ___Rolling Walker ___HD Rolling Walker (>250#)
___Rolling Walker w/ Seat ___HD Rolling Walker w/ Seat (>250#) **LON: _____**

o 1 – Wheelchair w/ Foot Rests & Anti-Tippers: ___Standard ___Lightweight ___ Heavy Duty*(250-300#)*
___ Extra Heavy Duty*(>300#)* **LON: ____**

o Elevating Leg Rests: ___ Left (1) ___ Right (1) ___Bilaterally (2) **LON: ____**

o 1 – Wheelchair Cushion: ___ General Use Back Cushion ___General Use Seat Cushion
___ Gel-Skin Protecting Cushion **LON: ____**

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

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

o 1 – Bedside Commode: ___Standard ___Heavy Duty *(>300#)* **LON: _____**

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

o Enteral Nutrition: _____ Qt: ____Syringes ____Gravity Sets ____ Pump Sets
Frequency: _____(cans per day) Total Qt Ordered: _____ (cans)
___Enteral Pump (1) with IV Pole (1)Settings: _____ mL / Hour X ___ Hrs Flush: _____ mL Every _____hr
Refills: _____ **LON: _____**

o Urinary Catheters: Qty per Month: _____ Refills: _____ **LON: ____** Frequency of Use: _____ Times Per Day
Select Type: ___Indwelling ___Intermittent ___Coude ___External Size: ____ French

o Other: _____ Qty: _____ LON: ____

Provider Name:_____ NPI:_____

Provider Signature:_____Date:_____

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