Detailed Written Order for Home Medical Equipment

Patient: _____DOB:_____ ICD-10: _____ Initial Date: _____

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

o 1 – Nebulizer with Compressor: **LON:_____**
Select all that apply: ___Nebulizer Mask (1/Mth) ___Disposable Nebulizer Kit (2/Mth)
___Non-Disposable Nebulizer Kit (1/6mths) Refills: ____

o 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: ____

o Diabetic Supplies: ____Lancets (100/Box) ___ Test Strips (100/Box)
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 (>300#) ___Rolling Walker ___HD Rolling Walker (>300#)
___Rolling Walker w/ Seat ___HD Rolling Walker w/ Seat (>300#) **LON: _____**

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

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

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#)*

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

o 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: _____**

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

o 1 – Lo-Plus Lumbar Support w/Stablizing Panel

o 1 or 2 Hinged Knee Brace ___Left ___Right

o 1 or 2 Wrist Splint ___Left ___Right

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

o Other: _____ Qty: _____ LON: ____

Provider Name:_____ NPI:_____

Provider Signature:_____Date:_____

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