

DME EQUIPMENT ORDER

Physician: _____
Address: _____
City, State, Zip: _____
Phone Number: _____
Fax Number: _____
NPI: _____

Patient Name: _____
DOB: _____
Order Date: _____
ICD10: _____
***Length of need (LON):
☐ 3 months ☐ 12 months (Lifetime)

Wheelchair → Complete Steps 1-3

Step 1: Select Base

☐ Standard 5'5"+ ☐ Heavy Duty 250-299
☐ Hemi 5'4" or less ☐ Extra HD 300 lbs +

Step 2: Leg Rest Type

☐ Elevating Legs ☐ Std Rest w/ Heel Loop

Step 3: Cushioning

☐ Seat Cushion ☐ Back Cushion

Other Options

☐ Anti-tips ☐ Transfer Board
☐ Wheel Lock Extensions ☐ O2 Carrier

Additional Documentation Required for the following options:

☐ Recline Back ☐ Seat Belt ☐ _____

Walker: ☐ With Wheels ☐ No Wheels
☐ 4-Wheeled, Seat, and Brakes
☐ Platform Attachment ☐ Hemi Walker

Cane: ☐ Single Point ☐ Quad Cane

Crutches: ☐ Standard ☐ Forearm-pair

Hospital Bed: w/ mattress and rails

☐ Semi Electric ☐ Fixed Height
☐ _____

Select Rail Style if other than full: ☐ ½ Rails

Alternating Pressure Pad & Pump: ☐

Low Air loss Mattress: ☐

Replacement Bed Mattress: ☐

Trapeze: ☐ **Hoyer Lift:** ☐

Commode: (Medicare/Medi-cal Only)

☐ Standard ☐ Heavy Duty ☐ Drop Arm

Bath Products: (Medi-cal Only)

☐ Shower Chair ☐ Tub Transfer Bench
☐ Grab Bars -QTY _____ (up to 3)
☐ Raised Toilet Seat

Other:

☐ _____

MD Signature _____ Date _____ Print Name _____