







DME ORDER

Patient Information	
Name _____	Date of Birth _____
<input type="checkbox"/> Please attach Facesheet	Date Service is Required:
Primary Diagnosis:	Estimated length of need (99 = Lifetime):

Prescribed DME			
Walkers:	<input type="checkbox"/> Adult Size (5'2" - 6'4") <input type="checkbox"/> Junior Size (4'4" - 5'7") <input type="checkbox"/> 4WW with seat <input type="checkbox"/> Pick Up - no wheels <input type="checkbox"/> Front Wheeled 3" wheels <input type="checkbox"/> Front Wheeled 5" Wheels		
Wheelchairs:	<input type="checkbox"/> Invacare 9000SL [K4] <input type="checkbox"/> General use seat cushion <input type="checkbox"/> General use back <input type="checkbox"/> Other		 w/c cushion
			 w/c back
Crutches:	<input type="checkbox"/> Adult 5'2" - 5'10" <input type="checkbox"/> Youth 4'7" - 5'3" <input type="checkbox"/> Tall 5'10" - 6'6"		

Non-Covered DME			
Commodes:	<input type="checkbox"/> Standard <input type="checkbox"/> Drop-arm <input type="checkbox"/> Bariatric <input type="checkbox"/> Bariatric drop arm <input type="checkbox"/> Other		
			
Shower Seats / Bath Benches:	<input type="checkbox"/> Chair with back <input type="checkbox"/> Chair without back <input type="checkbox"/> Transfer bench <input type="checkbox"/> Sliding transfer bench <input type="checkbox"/> Padded bench <input type="checkbox"/> Bariatric		
			

CONTACT PERSON _____	Phone# _____
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PHYSICIAN SIGNATURE _____	Date _____
I certify that the above-prescribed item(s) is/are medically indicated and in my opinion is/are reasonable and necessary with reference to the standards of medical practice and the treatment of this patient's condition	