DMEHC
HEALTHCARE PARTNERS
Phone: 480-930-4500
Fax: 888-505-5767

Standard Written Order

Patient Name: _____ DOB: _____ Height: _____ Weight: _____

Diagnosis :_____ Length of Need: _____ Start/Discharge Date: _____

Wheelchair ☐16" ☐ 18"Non-Standard seat Frame Width: ☐20"☐22"☐ 24"+ Depth☐18" ☐20"

☐Standard Wheelchair ☐Light Weight Wheelchair ☐ Heavy Duty Wheelchair (>250 lbs)☐ XHD>300lbs

☐Fully Reclining Back ☐Seat Cushion ☐Back Cushion ☐Elevating Leg Rests ☐Anti-Tippers ☐Brake ext

☐Power Wheelchair ☐Scooter **Other Order**:_____

Walker ☐Front Wheeled Walker ☐ Four Wheel Walker w/Seat Attachment

☐Heavy Duty Front Wheel Walker (>300 lbs) ☐Heavy Duty 4-Wheel Walker w/ Seat (>300 lbs)

Bed / Support Surfaces

☐Semi-Electric Hospital Bed (<350 lbs) ☐HD Hospital Bed (>350 lbs) ☐Patient Lift ☐Commode

Group I ☐Dry pressure(Foam) Mattress☐ Alternating Press Pad ☐ Low Air Loss Mattress (Group II)

PAP Services

CPAP _____CM/H2O BIPAP_____ CM/H2O ☐Heated Humidifier ☐Humidifier Chamber

☐Full Face Mask ☐Nasal Mask ☐Nasal Pillows ☐Head Gear ☐Cushions ☐Chin Strap ☐Tubing
☐Heated Tubing Filters: ☐Disposable ☐Reusable

Orthotics

☐Lumbar Brace ☐Lumbar Sacral Brace ☐ Thoracic Lumbar Sacral Brace ☐Knee Brace ☐AFO ☐Wrist
☐Hand Finger Brace

Incontinence Supplies:

☐Briefs / Diapers QTY _____ ☐Chuxs / Underpads QTY_____ Other _____

☐Wound Care Supplies : _____

☐Urological Supplies:_____

☐Ostomy Supplies: _____

*****(Please provide face-to-face chart notes that support medical necessity with the order)**

I hereby certify that the services are medically necessary and are authorized by me. The patient is under my care and is in need of the services listed above.

Treating Practitioner Signature: _____ Date: _____

Treating Practitioner Name: _____ NPI#: _____