Home Medical Equipment Prescription

adapthealth

Patient Information:

Patient Name: _____ Date of Birth:_____ / _____ / _____Order Date:_____ / _____ / _____

Patient Phone:_____-_____-_____ Diagnosis: _____ Length of Need:_____(99=Lifetime)

Address:_____

City:_____ State:_____ Zip Code:_____

Wheelchairs:

- ☐ Lightweight Wheelchair
- ☐ Standard Wheelchair
- ☐ Pediatric Wheelshairs 16x16
- ☐ Heavy Duty – 251+ Lbs.
- ☐ Extra Heavy Duty – 301+ Lbs.
- ☐ High Back Recliner
  - ☐ STD ☐ LT/WT ☐ High Strg LT/WT

Check off all accessories:

- ☐ Cushions Seat / Back*
- ☐ Rear Anti-Tippers
- ☐ Elevating Leg Rests
- ☐ Height Adjustable Arms
- ☐ Brake Extenders
- ☐ Seat Belt
- ☐ Oxygen Holder
- ☐ Transport Chair
- ☐ Standard Foot Rest
- ☐ Combo/Poly Fly Lightweight
- ☐ Swing Awar Arm Through
  - ☐ R ☐ L
- ☐ Amputee Rest
  - ☐ R ☐ L

Cusions:

- ☐ Standard Cusion Seat/Back*
- ☐ Roho Cusion Seat/Back**
- ☐ Other Skin Protection Seat/Back

Seat Width: ☐ 16" ☐ 18"

Non Standard Width:
☐ 20" ☐ 22" ☐ 24"
☐ 26" ☐ 28" ☐ 30"

Seat Depth: ☐ 16" ☐ 18"

Hemi Height: ☐ 17"

* Check Box For Bath or Circle One ** Patients must have at least history of a stage: Sacral Wound, Alzheimers, Parkinsons, Paralysis, or Plegia to qualify.

Oxygen/Respiratory:

- ☐ Home Oxygen Concentrator
- ☐ Portable w/ Conserving Nasal Cannula
  - ☐ % POX (e.g at/below 88%)
  - ☐ Liters Continuous
  - ☐ Diagnosis
- ☐ Nebulizer & Tubing**
  - ☐ Mask
- ☐ Suction Machine & Supplies
  - ☐ Oral / Trach
- ☐ Humidifer/PSI & Supplies_____%
- ☐ Overnight Ox

** Medical Diagnosis = COPD / Athsma / Pneumonia / Chronic Bronchitis

Enteral Feeding:

- ☐ Food Type:_____
- ☐ G-Tube ☐ J-Tube ☐ NG-Tube
- ☐ Blous & Syringe**
  - ☐ MLX
  - ☐ Per Day x 30 Days =
  - ☐ ML 30 Day Supply
- ☐ Pump, IV Pole, Bags & Syringes**
  - ☐ MLX
  - ☐ Per Day x 30 Days =
  - ☐ ML 30 Day Supply
- ☐ Refills _____ (1-12)

** Documentation required stating dysphagia along with swallow study *speech notes) and H&P)

Hospital Beds:

- ☐ Semi Electric Hospital Bed
  - ☐ Half Rail ☐ Full Raill
- ☐ Gel Overlay**
- ☐ Bariatric Bed (351+ Lbs.)
- ☐ Patient Lift (Hoyer)
- ☐ Trapeze
- ☐ Over Bed Table ($99)
- ☐ Bed Assist Rail ($80)
- ☐ Alternating Pressure Pad
- ☐ Pressure Mattress**Powered (low air loss)

*Gel Overlay Qualification = Partial immobility, accompanied by altered sensor perception, incontinence, or impaired nutritional or circulatory statusy
** Documentation REquired - Patients must have at least a healling stage III,IV or V would on the back, trunk or pelvis.

Ambulatory:

- ☐ Roling Walker (Paddle/ Tab
- ☐ Junior Walker 25''-32''
- ☐ Tall Walker w/ Extensions
- ☐ Bariatric Walker(301+Lbs.)
- ☐ Platform Attachment
  - ☐ RT ☐ LT
- ☐ Hemi Walker
- ☐ Patient Lift (Hoyer)
- ☐ Trapeze
- ☐ Over Bed Table ($99)
- ☐ Bed Assist Rail ($80)
- ☐ Alternating Pressure Pad
- ☐ Pressure Mattress Powered (low air toss)

Toilet/Bath:

- ☐ 3 in 1 Commode
- ☐ Bariatric Commode ($301 Lbs.)
- ☐ Drop Arm Commode
- ☐ Transfer Board
  - ☐ 24" ☐ 30"
- ☐ Raised Toilet Seat ($25)
- ☐ Raised Toilet Seat W/ Arms ($45)
- ☐ Toilet Safety Rail ($45)
- ☐ Shower Chair W/ Back ($35)
- ☐ Shower Chair W/ Arms ($65)
- ☐ Bariatric Shower Chair ($100)
- ☐ PVC Shower Chair W/ Arms ($65)
- ☐ Shower Transfer Bench ($55)
- ☐ Hand Shower Kit ($25)
- ☐ Suction Grab Bar ($20)
- ☐ Tub Rail ($45)

ADL/Other:

- ☐ Regular Grab Bar ($25)
  - ☐ 12" ☐ 16" ☐ 18" ☐ 24" ☐ 32"
- ☐ Tub Rail ($45)
- ☐ Hip Kit ($39) Includes dressing stick, reacher,shoe horn sock aid & long handle sponge
  - ☐ Leg Lifter ($10)
  - ☐ Reacher 26" ($16)
  - ☐ Reacher 32" ($20)
- ☐ Shoe Horn Plastic ($15)
- ☐ Long Sponge ($10)
- ☐ Dressing Stick ($10)
- ☐ Gait Belt ($15)
- ☐ Stock Aid ($10) Hard/Soft

Referring Practitioner Certification:

Letter and Certificate of Medical Necessity: As the referring practitioner, I certify that the above prescribed order is medically necessary based on my diagnosis and is part of my overall treatment plan for my patients. In my professional opinion, the equipment and/or supplies I have prescribed for my patient is reasonable and necessary for accepted standards of medical practice and treatment of my patient's condition and has not been prescribed as "convenience equipment".

Name:_____ **Signature:**_____

Date:_____ / _____ / _____ **NPI:**_____ **Your signature confirms the accuracy of the information provided on this form*