AZ Diabetic
386 Maple Ave E Ste 113
Vienna, VA, 22180-4755

DME Written Order Prior to Delivery

PHONE: 877-883-0001
FAX: 703-356-5516

MEDICAL EQUIPMENT ORDER

PATIENT NAME:______________________________ ORDER DATE:________________

PATIENT D.O.B:____________ SSN / MEDICARE #:________________ DISCHARGE DATE:______________

HEIGHT:_____ WEIGHT:_______PHONE NUMBER:____________________ LENGTH OF NEED:______________

WHEELCHAIR TYPE

(K0003) - QTY:1(ADJUSTABLE HEIGHT ARMS(E0973) QTY:2, ANTI-TIPPERS(E0971) QTY:2, WHEEL LOCK EXTENSIONS(E0961) QTY:2, HEEL LOOPS(E0951) QTY:2)

16" LIGHTWEIGHT 18" LIGHTWEIGHT 20" LIGHTWEIGHT & NON-STANDARD SEAT FRAME(E2201) - PATIENTS HIP MEASUREMENT EXCEEDS 19"

22" HEAVY DUTY(K0006) QTY:1(NON STANDARD SEAT FRAME (E2202) PATIENT'S HIP MEASUREMENT EXCEEDS 19", QTY:1, ANTI-TIPPERS(E09
EXTENSIONS(E0961) QTY:2, HEEL LOOPS(E0951) QTY:2

24" HEAVY DUTY(K0007) - QTY:1(NON STANDARD SEAT FRAME (E2203) PATIENT'S HIP MEASUREMENT EXCEEDS 22", QTY:1, ANTI-TIPPERS(E
EXTENSIONS(E0961) QTY:2, HEEL LOOPS(E0951) QTY:2

RECLINING WHEELCHAIR (K0001) - QTY:1(MANUAL RECLINING BACK(E1226) QTY:1, ANTI-TIPPERS(E0971) QTY:2, HEAD REST(E0955), ELEVATING LEG REST(K0195), QTY:2

16" RECLINING 18" RECLINING 20" RECLINING & NON-STANDARD SEAT FRAME(E2201) - PATIENTS HIP MEASUREMENT EXCEEDS 19"

CUSHIONS

BACK SUPPORT

CUSHION(E2611)/(E2612) SEAT CUSHION E2602)

- GENERAL USE (E2601)/(22E2602)

PROTECTION CUSHION (E26)/(

WHEELCHAIR ACCESSORIES

TRANSFER BOARD (E0705) Qty:1

LOWERED SEAT HEIGHT TO 17" (K0056)

WHEELCHAIR POSITIONING/SEAT BELT (E0978) Qty:1 *ARM TROUGH* (E2209) Qty:1 LEFT RIGHT

ELEVATING LEG RESTS (K0195) Qty:1

OXYGEN TANK CARRIER (E2208) Qty:1

ARTICULATING LEG RESTS (K0053) Qty:1

RESIDUAL LIMB SUPPORT (E1020) Qty:1 LEFT RIGHT

HOSPITAL BED (E0260/E026/E0294/E0295) QTY:1

HALF RAILSFULL RAILS NO RAILS

TRAPEZE - (250LB MAX) - (E0910/A9900) QTY:1

HOYER/PATIENT LIFT (E0630) QTY:1

HOYER SLING TYPE ________

FULL BODY SOLID

MESH WITH COMMODE OPENING

HOYER SLING SIZE

MEDIUM ____________

LARGE

EXTRA LARGE

PRESSURE ULCER PREVENTION AND TREATMENT

GEL FOAM OVERLAY MATTRESS (E0185) QTY: 1

COMPLETELY IMMOBILE *OR*

CHECK ONE:	*AND* (CHECK AT LEAST ONE):
LIMITED MOBILITY	A. IMPAIRED NUTRITIONAL STATUS
OR	B. FECAL OR URINARY INCONTINENCE
	C. ALTERED SENSORY PERCEPTION
ANY PRESSURE ULCER ON TRUNK OR PELVIS	D .COMPROMISED CIRCULATORY STATUS

LOW AIR LOSS MATTRESS WITH ALTERNATING PRESSURE THERAPY (E0277) QTY:1

COMMODES

3-IN-1 FOLDING COMMODE - (E0163) QTY:1

3-IN-1 DROP ARM COMMODE - (E0165) QTY:1

WALKERS

STANDARD WALKER (E0143) QTY:1

JUNIOR WALKER (E0143[2]) QTY:1

WALKER WITH A SEAT (E0143 & E0156) QTY:1

UPGRADE TO ROLLATOR ($50 UPGRADE COST)

IF YOU ARE IN NEED OF ANY ASSISTANCE IN FILLING OUT T
FORM PLEASE CALL:

877-883-0001

PLEASE FAX ORDER BACK TO
AZ Diabetic:

703-356-5516

I certify that this patient is under my care and that I, a Nurse Practitioner, or Physician's Assistant working with me, and had a face to face encounter that meets the physician face to face requirements with this patient.

PHYSICIAN NAME:______________________________NPI #:____________________

PHYSICIAN SIGNATURE:__________________________DATE:____________________

Note: Please maintain a copy of the Written Order, which must be kept on file for 7 years or longer if, required by state law.

Version: 061119