AdventHealth | Respiratory and Equipment

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Detailed Written Order (DME)

Patient Name:_____ Date of Birth: _____

Estimated Length of Need: (*Check One*) ☐ 99 Months (Lifetime) ☐ Or: _____ Diagnosis: _____

PLEASE ATTACH: Patient Demographics (including Height and Weight) and Signed Clinical Notes.

Wheelchairs: Sizes 16", 18", 20", 22", 24"

- ☐ Lightweight (Size:_____)
- ☐ Standard (Size:_____)
- ☐ Heavy Duty (Size:_____)
- ☐ Hemi (Size:_____)
- ☐ Extra-Wide (Size:_____)
- ☐ Transport (19" only)
- ☐ Reclining (16", 18", 20")
- ☐ Standard Foot Rests
- ☐ Elevating Leg Rests
- ☐ Anti-Tippers
- ☐ Wheel Lock Extensions
- ☐ Safety Belt
- ☐ Standard Cushion (Size:_____)
- ☐ Gel Cushion (Size:_____)
- ☐ Roho Cushion (18" only)
- ☐ Arm Trough
- ☐ Other: _____

Hospital Beds:

- ☐ Semi-Electric
- ☐ Full Electric (Upgrade Fee Applies)
- ☐ Bariatric (Over 350lbs)
- ☐ Gel Overlay
- ☐ Alternating Pressure Pad
- ☐ Standard Low Air Loss
- ☐ Bariatric Low Air Loss
- ☐ Standard Trapeze Bar
- ☐ Free Standing Trapeze Bar
- ☐ Hoyer Lift: (Choose Below)
  - ☐ Standard
  - ☐ Electrical (Over 400lbs)
  - ☐ Heavy Duty
- ☐ Hip Kit *
- ☐ Transfer Board (24", 30", 35") *
- ☐ Half Rail
- ☐ Full Rail
- ☐ Other: _____

Walkers:

- ☐ Walker (Front-Wheeled)
- ☐ Walker (Front-Wheeled w/ Seat)
- ☐ Walker (Heavy Duty) (Over 300lbs)
- ☐ Walker (Heavy Duty w/ Seat) (Over 300lbs)
- ☐ Hemi Walker
- ☐ Arm Rests: Left / Right
- ☐ Leg Rests: Left / Right

Ambulatory:

- ☐ Knee Scooter *
- ☐ Standard Crutches
- ☐ Forearm Crutches
- ☐ Canes:
  - ☐ Straight
  - ☐ Offset
  - ☐ Bariatric
- ☐ Quad Canes:
  - ☐ Small
  - ☐ Large
  - ☐ Bariatric
- ☐ Other:_____

Bath/Shower:

- ☐ Commodes: (Not covered by UHC)
  - ☐ Standard
  - ☐ Heavy Duty
  - ☐ Drop Arm
  - ☐ Heavy Duty Drop Arm
  - ☐ Padded
- ☐ Elevated Toilet Seat *
- ☐ Bath Bench *
- ☐ Bariatric Bath Bench *
- ☐ Transfer Bench
- ☐ Bath Bench w/ Padded Arms
- ☐ Other: _____

***Indicates an item that's not covered by insurance.**

I certify that this patient is under my care and that I, or a nurse practitioner or physician's assistant working with me, ordered the above mentioned items.

X Printed Physician Name: _____

X NPI: _____

X Date: _____

X Physician Signature: _____

X Signature Date:_____Time: _____

Patient Sticker