DOCTOR’S ORDER FORM (Rx)

Ship to:  Home  Facility/Clinic

HOME MEDICAL EQUIPMENT

☐ Blood pressure machine, auto (A4670)
☐ Nebulizer (E0570, A7005)
☐ Rollator, wheeled walker (E0143, E0156)
☐ Wheelchair, lightweight manual (K0003)

☐ Other specify):________________________________________

Length of need (1-99) _____ months.
Pt Ht: _____  Pt Wt: _____

INCONTINENCE SUPPLIES

Style / Type:
☐ Disposable adult diapers. Waist:_____ inches. Avg. daily usage:______
☐ Disposable pull-ups. Waist:_____ inches. Avg. daily usage:______
☐ Disposable bed liners, 30 X 30 (Chux); avg. daily usage:______
☐ Disposable gloves, non-sterile
☐ Disposable pads; Average daily use:________
☐ Other:_________________  ☐ Length of need (1-99) _____ months.

ORTHOTICS (PRE-FABRICATED)

☐ Back support belt (L0625)  Waist Size (inches):____________
☐ Wrist splint, universal size (L3908)  Circle: L    R
☐ Knee Brace (L.1812)  Size (Knee Circumference):_________ inches
☐ Other specify):________________________________________

ASSIGNMENT OF BENEFITS:  The undersigned hereby authorizes Advanced Home Medical, Inc. to request on my/our behalf and to collect directly all public and private insurance benefits due to products supplied patient by Advanced Home Medical, Inc. In the event payments for insurance benefits are made directly to any of the undersigned, the payee will endorse to Advanced Home Medical, Inc. all checks for such payment.

☐ Check this box and initial if products were already received. Initials:______

This form must be SIGNED & DATED by the prescribing Physician before the equipment may be dispensed.

__________________________________________________________
 PHYSICIAN’S SIGNATURE                                  DATE

Physician’s signature certifies that the above represents his/her judgment of the patient’s need for the equipment and/or supplies