



DURABLE MEDICAL EQUIPMENT AND SUPPLIES

Questions to help process the patient request for medical assistance accurately.

<input type="checkbox"/> New	<input type="checkbox"/> Purchase	<input type="checkbox"/> Short Term (3 mos. or less)	FOR OFFICE USE:
<input type="checkbox"/> Used	<input type="checkbox"/> Rental	<input type="checkbox"/> Long Term (6 mos. or longer)	
<input type="checkbox"/> New or Used	<input type="checkbox"/> Donation/Charity	<input type="checkbox"/> Temporary (1 mo. or less)	

PLEASE NOTE: Due to health regulations most supplies or equipment are not returnable once opened.

If a patient has a disability and need durable medical equipment or supplies please provide in detail what is necessary and please list the quantity if applicable.

Example:

1. A patient has a neck injury or neck weakness and may need a headrest or neck pillow for support.
2. When requesting a walker, does the patient need seating, what type of walker, what is the patient height and weight?
3. A patient need a walker because there is a greater stability and security than provided by a cane or crutches.
4. When requesting a wheelchair, does the patient require a leg lift due to a leg injury? Does the patient used a transfer board? If so, this may require removable or adjustable arms.

Type of equipment or supplies?

List the use for the equipment or supplies?

Provide an exact description, including all parts and/or accessories necessary for the use and operation of the equipment.

Patient's Name: _____ **Date of Birth:** _____

Delivery Options: Delivery Exchange Pick-Up Other

Equipment delivered to the patient's home? Yes No

Equipment delivered to hospital before discharge? Yes No

Facility Representative:

Title:

Facility/Location:

Date: