



DME / SUPPLIES ORDER FORM

6415 S. Fort Apache Rd. STE# 170, Las Vegas NV 89148
 Phone: (702) 696- 1527 Fax: (702) 444- 4154

PATIENT INFORMATION	INSURANCE
Name: _____ DOB: _____	Primary: _____
Address: _____ Apt: _____	Policy#: _____
City: _____ State: _____ Zip Code: _____	
Phone: _____ Cell: _____ Gender: _____ HT: _____ inches WT: _____	Secondary: _____
**Please attach copies of the following: Prescription/RX, Chart Notes, Demographics & Insurance Card/Information	Policy#: _____

DURABLE MEDICAL EQUIPMENT & SUPPLIES

Equipment & Rehabs	Ambulatory Aids	Orthopedic & Bracing	Bathroom Aids
<input type="checkbox"/> Scooter <input type="checkbox"/> Manual Wheelchair <input type="checkbox"/> Transport Wheelchair <input type="checkbox"/> Wheelchair Cushion <input type="checkbox"/> Lift Chair <input type="checkbox"/> Other: _____	<input type="checkbox"/> Walker <input type="checkbox"/> Rollator with Seat & Brake <input type="checkbox"/> Cane <input type="checkbox"/> Quad Cane <input type="checkbox"/> Crutches	<input type="checkbox"/> Knee Brace <input type="checkbox"/> Back Brace <input type="checkbox"/> Elbow Support <input type="checkbox"/> Wrist Splint/Brace <input type="checkbox"/> Ankle Support <input type="checkbox"/> Hip Brace <input type="checkbox"/> Neck Brace <input type="checkbox"/> Shoulder Brace <input type="checkbox"/> Walker Boot <input type="checkbox"/> Custom: _____	<input type="checkbox"/> 3-in-1 Commode <input type="checkbox"/> Raised Toilet Seat <input type="checkbox"/> Shower Chair <input type="checkbox"/> Transfer Bench
Soft Medical Goods <input type="checkbox"/> Wound Care Supplies <input type="checkbox"/> Ostomy Supplies <input type="checkbox"/> Tracheostomy Supplies	Diabetic Supplies <input type="checkbox"/> Glucometer <input type="checkbox"/> Test Strips <input type="checkbox"/> Diabetic Shoes/Inserts <input type="checkbox"/> Compression Stockings <input type="checkbox"/> Blood Pressure Monitor		Notes:

INCONTINENCE

<input type="checkbox"/> Small Briefs QTY: _____ <input type="checkbox"/> Medium Briefs QTY: _____ <input type="checkbox"/> Large Briefs QTY: _____ <input type="checkbox"/> X-Large Briefs QTY: _____ <input type="checkbox"/> XX-Large Briefs (PA Req) QTY: _____ <input type="checkbox"/> Youth Briefs QTY: _____ <input type="checkbox"/> Under pads QTY: _____	<input type="checkbox"/> Small Pull-Ups QTY: _____ <input type="checkbox"/> Medium Pull-Ups QTY: _____ <input type="checkbox"/> Large Pull-Ups QTY: _____ <input type="checkbox"/> X-Large Pull-Ups QTY: _____ <input type="checkbox"/> Youth Pull-Ups QTY: _____ <input type="checkbox"/> Liners/Shields/Guards QTY: _____ <input type="checkbox"/> Other: _____ QTY: _____
Frequency (Select One): 3-4 X/Day: _____ 5-6X/Day: _____ Refills: <u>99</u> Substitutions Allowed: _____ 12/12 Refills: <u>12</u>	Diagnosis: _____

Physician Name: _____ **NPI#:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Phone: _____ **Fax:** _____ **Signature:** _____ **Date:** _____