# DME ORDER FORM

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www.careconceptshme.com
Care Concepts, Inc.

PATIENT NAME:______________________________________________ TEL: (      )_________________________
MEDICARE # ____________________MEDICAL # __________________OTHER________________
ADDRESS:_______________________________________CITY:________________________ ST:_______ ZIP:__________
WEIGHT:____________ HEIGHT:__________ D.O.B.___________________ FACILITY:___________________________

## ORTHOTICS / PROSTHETICS

**BACK SUPPORTS**

( ) Dorso-Lumbar
( ) Lumbo-Sacral
( ) Sacro-Lliac
( ) Rib Belt

**BRACE**

( ) Knee Brace ( ) Sm ( ) Md ( ) Lg ( ) Xlg
( ) Ankle Rt.___ Lt.___
( ) Elbow Rt.___ Lt.___ // ROM Dbl. Upr.
( ) Wrist Rt.___ Lt.___
( ) Shoulder Rt.___ Lt.___

Other Orthopedic Supports:_________________________________

## DURABLE MEDICAL EQUIPMENT

( ) Walker Folding // with wheel // with seat
( ) Oxygen Concentrator (CMN Required)
( ) Hospital Bed // Semi-Electric // manual (CMN Required)
( ) Utility bath seat ( ) w/back
( ) Commode (bedside)
( ) Raised Toilet Seat
( ) Bed Pan ( ) Urinal M/F

( ) Cane Orthopedic // Quad ( ) Wheel pad
( ) Nebulizer with compressor for positioning
Equalization
___________________________________
___________________________________
___________________________________

( ) Mattress Overlay (Decubitus STAGE1)Special Form ( ) Mattress Alternating / low Air Loss(Decubitus STAGEII)Special Form

## ( ) Blood Glucose Monitor

Last three FBS Results
Date________FDS=______ ( )Chemstrips _____each

Is Patient Capable of:
A.Using monitor w/out assistance and or learning to use monitor? Yes / No Date________FBS=______ ( ) Lancets _______each
B.Widely fluctuating blood sugar before meals? Yes / No
C.Frequent episodes of insulin reactions? Yes / No Date________FBS=______ ( ) Alcohol _______each

Does Patient Use Insulin Yes / No NPH=___u Date____FBS refills______

## DIAGNOSIS

( ) Ambulation limited to (    ) steps
( ) Amputation of
( ) Angina pectoris
( ) Arthritis
( ) Asthma
( ) Bronchial Asthma
( ) Bursitis
( ) Carpal Tunnel Syndrome
( ) Cellulitis
( ) Cervical Radicllities
( ) CHF
( ) COPD
( ) Chronic Incontinence
( ) Chronic Intractable Pain // Lumbar // Cervical // Thoracic // Arm // Knee
( ) Patient is unable of using regular toilet facility

( ) Decubitus Ulcer:______________
( ) Diabetes Mellitus // Insulin Dependent
( ) Discogenic Disease
( ) Hemarthrosis // Knee // Ventral
( ) Hernia // Inguinal // Umbilical // Ventra l
( ) Low Back pain Syndrome
( ) Lymphedema
( ) Organic Brain Syndrome
( ) Osteoporosis

( ) Degenerative Osteoarthritis // Spinal // Knee // Ankle // Cervical
( ) Paralysis
( ) Peripheral Vascular Disease
( ) Radiculitis Lumbar Syndrome
( ) Renal Failure ( ) Venous Insuff
( ) Sciatica
( ) Spondylosis
( ) Sprain / Strain
( ) S/P CVA, Weakness, Fatigue
( ) Seizure Disorder
( ) S/P Fracture of ______________

( ) S/P Open Heart Surgery
( ) S/P Mastectomy
( ) Transient Cereb/ischemia
( ) Unable to use bathroom
( ) Varicose Veins/
( ) Weakness
________________________
________________________
________________________

Other: ________________________________________________

I certify that the aforementioned is correct. I understand that intentional misrepresentation of diagnosis, services or medical necessity documentation hereby submitted, constitutes and may be subject to prosecution and or imposition of civil money penalties by federal government.

Address: ____________________________________________________

____________________________________________________

Tele: __________________________ Fax: _______________________

Doctor's Signature:_______________________________ Date:_____________ LIC#____________ UPIN#______________

Print Name:_____________________________________________________________________________________________