HEALTH AID OF OHIO

STANDARD WRITTEN ORDER

Please include
Face Sheet & Diagnosis
Fax: 216-252-4930

Order Date: _____/_____/_____

_____ _____
Patient Name Discharge Date/Time

_____Policy #_____ _____
Insurance Phone

_____ _____
Address Date of Birth

_____ _____ _____
City/Zip Code **Height **Weight Length of Need (99=lifetime)

Deliver equipment to: ☐ **Patient home** ☐ **Facility** / Room #

Hospital Bed
☐ Semi-Electric (up to 350lbs.)
☐ Heavy Duty (over 350 lbs.)
☐ Ex. Heavy Duty (over 650 lbs.)

Bed Accessories
☐ Full Rails (2ea) ☐ Half Rails (2ea)
☐ Trapeze Bar
☐ Hoyer Lift with Sling
☐ Sling with commode opening
☐ Sling – Specify Below:
_____

Support Surfaces
☐ Alt Press Pad and Pump
☐ Foam/Gel Overlay
☐ Low Air Loss/Alt Pressure

CPAP/BiPAP
☐ CPAP: _____cm H_2O (4-20)
☐ AutoPAP: ____to____ cm H_2O
☐ BiPAP: I _____/E_____ cm H_2O
Res Rate: _____
☐ Mask to fit (1/3 month)
OR Mask Type: _____
☐ Headgear (1/6 month)
☐ Heated Humidifier (1/6 month)
☐ Tubing (1/3 month)
☐ Heated Tubing (1/3 month)
☐ Disposable Filter (2/month)
☐ Reusable Filter (1/3month)

Aids to Daily Living
☐ 3 in 1 Commode
☐ Heavy Duty Commode
☐ Drop Arm Commode
☐ HD Drop Arm Commode
☐ Transfer Bench
☐ Shower Chair (back / no back)
☐ Raised Toilet Seat

Ambulatory Devices
☐ Cane ☐ Quad Cane
☐ Crutcher ☐ Rollator
☐ Folding Walker
☐ Walker with 5"wheels
☐ Heavy Duty (over 300 lbs.)
☐ Junior (5'2" or less)
☐ Platform attachment

Oxygen
☐ Oxygen LPM ____ Via:_____
☐Rest ☐Exertion ☐ Nocturnal
☐ Continuous
☐ Concentrator ☐ Portable Gas
☐ Evaluate for & Dispense O_2 Conserving Device
If O2 Sat is maintained at _____% during evaluation.

Wheelchair
☐ Standard ☐ Light Weight
☐ High Strength Lt. Wt.
☐ Heavy Duty
☐ Hemi STF Height (17")
Width: ☐ 16 ☐ 18 ☐ 20 ☐ 22
Depth: ☐ 16 ☐ 18
☐ Arm Trough ☐ Stump Support

Wheelchair Accessories
☐ Footrest (2ea)
☐ Elev. Legs (2ea)
☐ 3" Foam Cushion
☐ General Use back
☐ Full Arms (2ea)
☐ Desk Arms (2ea)
☐ Reclining Back ☐ Seat Belt
☐ Anti-Tippers (2ea)
☐ Wheel Lock Extensions (2ea)
☐ Transfer Board

Nebulizer
☐ Nebulizer (1/5 years)
☐ Admin Set (2/month)
☐ Mask (2/month)

Other:

Medicaid, Medicare and Medicare HMO plans require a face to face exam prior to ordering and dispensing DME. Please include chart notes, proof of face to face exam, face sheet, insurance information and diagnosis list with every order.

_____ _____
Physician Name (Print) Phone Number

_____ _____ _____
Signature Date NPI

Would you like a phone call verifying receipt of this fax: ☐ YES ☐ NO

Referral Contact Name_____ **Facility**_____

Contact Number_____ **Contact Fax**_____