



Please fax your patient's insurance and demographic information along with this form.

HME E-Z SCRIPT

- BOARDMAN (330) 758-0595 Fax (330) 726-2229
CANTON (330) 492-4300 Fax (330) 492-7886
CLEVELAND (216) 341-7020 Fax (216) 341-7023
GIRARD (330) 545-6700 Fax (330) 545-5555
EAST LIVERPOOL (330) 385-6412 Fax (330) 385-3255
SHARON (724) 962-5670 Fax (724) 962-5673

TOLL FREE 1-800-443-3390
TOLL FREE FAX 1-800-952-5352

WARREN (330) 395-7252 Fax (330) 373-1190

Date: (Date goes here)
Patient Name: (Patient's Name goes here)
Patient Phone #: (Patient Phone Number goes here)
Address: (Patient Address Goes Here - Street, City - Zip)
Diagnosis/Diagnosis Code: (Specific to required equipment)

OrderedBy: (Physician Name)
Height:(Pt. height) Weight:(Pt. weight)
DurationofNeed:(specify days/months)

AIDS TO DAILY LIVING

- Walker Wheeled Walker Hemi Walker
Extra Wide Walker Walker Platform Attachment
Wheeled Walker w/Seat

- Cane Sidestepper
Sm. Base Quad Cane Lg. Base Quad Cane
Offset Cane Straight Cane
Crutches Crutch Platform Attachment

- Extra Wide Commode Drop Arm Commode Bedside Commode
Confined to a single room or to one level of their home environment with no bathroom facilities.
Bed/Chair Confined No indoor bathroom facilities.

HOSPITAL BED

- Manual Hospital Bed Semi-electric Hospital Bed Full-electric Hospital Bed
Fixed Height Hospital Bed Variable Height Hospital Bed Half Rails Full Rails

- Accessories: Bed-mount Traction Trapeze: Bed-mount Free-standing
Patient Lift Alternating Pressure Pad & Pump (APP)
Sprinkle Gel Overlay

- Condition Expected to last up to 1 month and patient requires aid positioning
Bed required to alleviate pain. Requires bed lowered to transfer bed to chair/stand.
Condition requires HOB elevation up to 30 degrees (CHF, COPD, Aspiration).
Device needed to assist to sitting to sitting position for changes in position, or getting in or out of bed.

INCONTINENCE SUPPLIES

- Urinary Incontinence Also list DX causing incontinence
Bowel Incontinence

Please indicate supplies requested:

WHEELCHAIR

- Type & Weight Limit: Standard W/C (up to 250 lbs.) Heavy Duty W/C (over 250 lbs.) Seat Cushion
Lightweight W/C (under 250 lbs.) X-tra Heavy Duty W/C (over 300 lbs.) Back Cushion

Size: (Seat Width) Child 16 18 20 22 24

- Hemi Height 17 1/4 Tall Back Elevating Legrest Brake Extensions Stump Support
Super Hemi Height under 17 Reclining Back Footrests Anti-tippers (pair) Amputee Set Back (Bi-Lateral AKA)
Tall Seat over 21 Quick Release Axle w/Heel Loops Pelvic Strap

- Other:
Condition confines client to bed or chair & required to move about in residence.
Is patient using any other ambulatory aid? Yes No If yes, please list other ambulatory aid:

TRANSPORT WHEELCHAIR

- Wheelchair required for use inside of home. Heavy Duty Transport Wheelchair - Gemco (over 300 lbs.)
Standard Transport Wheelchair (up to 250 lbs.)
Size: 17 19

I certify that the medical necessity information above is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE: (Physician Signature goes here) DATE: Mo / Day / Yr
Printed Name: (Print Physician Name) Address: (Physician Street Address goes here)
Phone: (Office Phone) UPIN #: (enter UPIN here) City/State/Zip: (Physician City/ST/Zip goes here)