WWW.BOARDMANMEDICALSUPPLY.COM

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

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

NURSING 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

EAST LIVERPOOL
(330) 385-6412
Fax (330) 385-3255

GIRARD
(330) 545-6700
Fax (330) 545-5555

SHARON
(724) 962-5670
Fax (724) 962-5673

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

Date: ____________________

Patient Name: ____________________

Patient Phone #: ____________________

Address: ____________________

Diagnosis/Diagnosis Code: ____________________

OrderedBy: ____________________

Height: ____________ Weight: ____________

Duration of Need: ____________________

❑ TENS

❑ Replacement Wires

❑ Supplies Electrodes, Batteries, Battery Charger, Skin Prep, Conductive Paste/Gel, Adhesive Remover

❑ PHOTOTHERAPY

❑ Bili Level: ____________________

❑ CPM

Date of Surgery: ____________________

Date CPM Applied in Hospital: ____________________

Date of Delivery: ____________________

Date of Discharge from Facility: ____________

❑ **Polar Care**
- ❑ *Knee*
- ❑ *Shoulder*

❑ GLUCOMETER

❑ Patient is Insulin Dependent

❑ Patient is Non-Insulin Dependent

Patient tests ________x per day.

❑ **Supplies:**
Test Strips
Lancets
Lancet Device
Control Solution

❑ ENTERAL

❑ IV Pole ❑ Nutrition Pump

❑ Oral
❑ Bolus/Syringe Fed
❑ Gravity Fed
❑ Related Supplies

Nutrition Required ____________________

CC/Day ____________

CC/HR ________

Calories/Day ________

❑ SUCTION & RELATED SUPPLIES

❑ Suction Tubing
❑ Suction Yankauers
❑ Suction Catheters ________size
❑ Suction Filters

❑ LYMPHEDEMA PUMP

❑ Leg Sleeve
❑ Arm Sleeve

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: ____________________ DATE: _____/_____/_____

Printed Name: ____________________ Address: ____________________

Phone: ____________ NPI #: ____________ City/State/Zip: ____________________

Revised: 9/15/10