DME REFERRAL FORM

PATIENT INFORMATION *(Complete the following or send patient's demographic sheet)*

Last Name _____ First Name _____ Date of Birth _____

Gender ☐M ☐F Height:_____ Weight: _____ Home Phone _____ Work/Mobile Phone _____

Home Address _____ City _____ State _____ Zip _____

Medicare # _____ Medicaid # _____ Other _____ Facility _____

Email ID: _____

ORTHOPEDICS / PROSTHETICS

SUPPORT BRACES

☐ Neck Brace
☐ Back Brace
☐ Knee Brace ☐S ☐M ☐L ☐XL
☐ Orthopedic Walker Boot - Rt.__ Lt.__
☐ Ankle - Rt.__ Lt.____
☐ Wrist - Rt.___Lt.___
Other Orthopedic Support:_____

DURABLE MEDICAL EQUIPMENT

☐ Oxygen Concentrator (CMN Required)
☐ Hospital Bed ☐ Semi Electric ☐ Fully Electric (CMN Required)
☐ Mattress ☐ Gel Overlay ☐ Air Loss (Alternating Pressure)
☐ Shower Chair
☐ Tub Transfer Bench
☐ Commode (3 in 1 Bedside)

☐ Wheel Chair Manual (**Size**: ☐ 18" ☐ 20" ☐ 22" ☐ 24")
☐ Wheel Chair Electric ☐ Power Scooter (CMN Required)

☐ Walker ☐ With wheel ☐ Seat ☐ Basket
☐ Crutches
☐ Cane Orthopedic ☐ Single Point ☐ Quad
☐ Nebulizer & Supplies
☐ Blood Pressure Monitor

☐ Glucometer & Supplies
* PT Needs to Check _____ Times per Day

Other Equipment Please specify below

_____
_____

DIAGNOSIS

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

COMMENTS IF ANY _____

_____
_____
_____

✔ **Prescriber Certification:** I certify the above therapy is medically necessary and that the information above is accurate to the best of my knowledge

Sig as Directed Everyday Lifetime

Physician Signature:_____ **Date:**_____ **Office contact:**_____

Physician Name:_____ **NPI #**_____

Physician Address:_____ **Phone #**_____ **Fax #**_____

FAX TO: 713-661-4828

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