CAROLINA'S HOME MEDICAL EQUIPMENT INCORPORATED

NAME OF FACILITY: _____
REFERRAL CONTACT: _____ PHONE: _____

Account Executive - Jason Barbee; Phone (704) 288-6394; Office (704) 846-7503; Fax (704) 846-7911

General Equipment Detailed Written Order Prior to Delivery (DWOPD)

PATIENT'S NAME: _____ PHONE: _____

PATIENT'S HEIGHT: _____ WEIGHT: _____ DATE OF BIRTH: _____

SNF/REHAB/HOSPITAL DISCHARGE DATE: _____

PRIMARY CARE PHYSICIAN'S NAME: _____

DIAGNOSIS: _____

EQUIPMENT NEEDED: (check items)

The items listed below DO NOT require office visit notes, but require a physician's VERBAL or SIGNED order prior to delivery.

- □ SINGLE POINT CANE
- □ QUAD CANE - BASE SIZE: S L
- □ WALKER
- □ WALKER WITH WHEELS
- □ ROLLATOR (walker with wheels and seat)
- □ HEMI WALKER
- □ CRUTCHES
- □ PLATFORM ATTACHMENT (check one below): □ R □ L □ Bilateral
- □ RAISED TOILET SEAT
- □ TRANSFER BENCH
- □ LEG EXTENSTIONS FOR WALKER (SET OF 4) (FOR PATIENTS 6' OR TALLER.)
- □ SHOWER CHAIR (seat with back support)
- □ COMPRESSION HOSE _____ MMHG
- □ TRANSFER BOARD: 24" 30"

The items listed below REQUIRE office visit notes & a physician's VERBAL or SIGNED order prior to delivery.

- □ BEDSIDE COMMODE
- □ DROP ARM COMMODE
- □ TRAPEZE BAR
- □ POWER WHEELCHAIR
- □ SCOOTER
- □ PT OR OT TO EVALUATE & TREAT FOR MOBILITY NEEDS (Choose One): □ HOME HEALTH OR □ SEATING CLINIC

The items listed below REQUIRE office visit notes & a physician's SIGNED order prior to delivery.

- □ DRY PRESSURE MATTRESS
- □ ALTERNATING PRESSURE PAD W/PUMP
- □ PATIENT LIFT, HYDRAULIC OR MECHANICAL, INCLUDES SLING
- □ POWERED PRESSURE-REDUCING AIR MATTRESS (LOW AIR LOSS MATTRESS)
  # of ulcers: _____; stage(s) of ulcers: _____
- □ SEMI ELECTRIC HOSPITAL BED WITH: (Choose one option:)
  - □ MATTRESS & SIDE RAILS
  - □ NO MATTRESS & SIDE RAILS
  - □ MATTRESS & NO SIDE RAILS
  - □ NO MATTRESS & NO SIDE RAILS
- □ SEAT LIFT MECHANISM INCORPORATED INTO A COMBINATION LIFT-CHAIR MECHANISM (LIFT CHAIR)

Name of Referring Physician (Print): _____ **Length of Need:** _____

Physician's Signature: _____
(if not available, must have verbal order or doctor's order)

NPI: _____ **Start/Date of Order*:** _____

SUBSTITUTION PERMITTED TO PROVIDE A QUALIFYING SERVICE.

*** - MUST have start/date of order**