FAX ORDER FORM

☑ DELIVER TO HOME
☐ DELIVER TO FACILITY
☐ FACE SHEET INCLUDED

REFERRAL SOURCE: DFW REFERRAL CONTACT: (972) 675-7313
PATIENT NAME: M FRANCES Vanvleet SS#: 466-20-7592
DOB: 1926-01-16 HT: 61.00 in WT: 67.59 kg SEX: Female
PHONE: 469-387-6467 EMERGENCY CONTACT:
ADDRESS: 2061 Rosebud Dr. Irving Texas 75060
INSURANCE: (NAME / ID) Medicare B Texas/466207592A SECONDARY INSURANCE
PRIMARY PHYSICIAN: Sumana Ketha, M.D. NPI: 1962447805
PHYSICIAN PHONE: (972)-675-7313 FAX: (972)-675-7313
DIAGNOSIS / ICD-9: Dorsalgia, unspecified. M54.9 LENGTH OF NEED: 99

MOBILITY

WHEELCHAIR SIZE # 16, 18, 20, 22 OR 24 INCHES
☐ STANDARD ☑ LIGHT WEIGHT MANUAL WHEELCHAIR
☐ BARIATRIC ☐ ELR'S
☐ STANDARD CUSHION ☐ GEL ☐ ROHO / AIR CUSHION
☐ **POWER WHEELCHAIR & ACCESSORIES**
☐ SCOOTER ☐ REHAB MOTORIZED WHEELCHAIR

CLINICAL ASSESSMENTS

☐ PULSE OXIMETRY / DAY TIME
☐ OVERNIGHT ☐ SLEEP STUDY CPAP / BiPAP

RESPIRATORY

☐ CPAP / BIPAP _____
☐ MASK SIZE _____
☐ NASAL ☐ FULL FACE _____
☐ OXYGEN (LPM _____ O2 SAT_____)
☐ SUCTION MACHINE
○ TRACH / CATH SIZE _____
○ ORAL
☐ TRACH CARE KITS ☐ NEBULIZER

ENTERAL FOOD

☐ FORMULA _____
☐ FLOW RATE _____
☐ CANS OR CALORIES / DAY _____
☐ BOLUS

HOME CARE BEDS

☐ HOSPITAL BED
☐ FULL RAILS HALF RAILS
☐ HEAVY DUTY LO BED

DECUBITIS CARE

☐ GEL OVERLAY MATTRESS
☐ LOW AIR-LOSS MATTRESS
FOR LOW AIR-LOSS INDICATE LOCATION OF DECUBITIS ULCER:
☐ UPPER BACK (707.02)
☐ LOWER BACK (707.03)
☐ HIP (707.04)
☐ BUTTOCKS (707.05)

DIABETIC SUPPLIES

☐ GLUCOSE MONITOR
☐ TEST STRIPS
☐ LANCETS
TESTING _____ X A DAY INSULIN DEPENDENT _____
NON-INSULIN DEPENDENT _____

INCONTINENCE SUPPLY

☐ DIAPERS / PULL-ON (XXL, XL, L, M, S, SY)
☐ UNDER PADS
☐ BARRIER CREAM
☐ WIPES
☐ LINER PADS

BATHROOM

☐ 3-IN-1 COMMODE
☐ DROP ARM ☐ HEAVY DUTY
☐ ELEVATED TOILET SEAT*
☐ SHOWER CHAIR*
☐ HEAVY DUTY* ☐ W / BACK*
☐ TRANSFER BENCH*
☐ HEAVY DUTY*

AMBULATORY

☐ CANE ☐ QUAD CANE
☐ CRUTCHES
☐ HEMI WALKER (SIDE)
☐ ROLLING WALKER
☐ JUNIOR ☐ HEAVY DUTY
☐ NO WHEELS BASKET / POUCH*
☐ SEAT ATTACHMENT
☐ PLATFORM ATTACHMENT

☐ ROLLATOR

☐ JUNIOR ☐ HEAVY DUTY ☐ REGULAR

OTHER

☐ PATIENT LIFT
☐ STD SLING ☐ COMMODE OPENING
☐ OTHER PLEASE SPECIFY:_____

LETTER OF MEDICAL NECESSITY: I, THE UNDERSIGNED, CERTIFY THAT THE ABOVE PRESCRIBED DURABLE MEDICAL EQUIPMENT IS MEDICALLY NECESSARY AS PART OF MY TREATMENT FOR THIS PATIENT IN MY OPINION, THE EQUIPMENT PRESCRIBED IS REASONABLE & NECESSARY FOR ACCEPTED STANDARDS OF MEDICAL PRACTICE AND TREATMENT OF THIS PATIENT'S CONDITION AND HAS NOT BEEN PRESCRIBED AS "CONVENIENCE EQUIPMENT".

PHYSICIAN SIGNATURE: S. Ketha Electronically Signed By: Sumana Ketha, M.D. DATE: 11 / 01 / 2016

PLEASE ATTACH A COPY OF INSURANCE CARD AND ADDITIONAL DOCUMENTATION REQUIRED.
TO PROCESS THE ORDER, PLEASE FAX THE ORDER FORM TO:

All In Medical Supply

227 MARTHA STREET, EULESS, TX 76040
PH # 817-868-1700 PH # 800-948-4757
FAX # 817-868-1701 FAX # 866-948-4758