

Non-Respiratory DME

Please call (800) 940-5151 before faxing to ensure delivery.

Fax: (800) 676-3127

Patient Name: _____ Date of Birth: _____

Diagnosis: _____

Ordering Physician: _____ Phone: () _____

Contact Person: _____ Phone: () _____

Patient's Height: _____ Weight: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Subscriber's Social Security Number: _____

Emergency Contact: _____ Phone: () _____

Standard wheelchair: Yes No
with ELRs

Lightweight wheelchair: Yes No
with ELRs

Commode: Yes No
Extra wide: Yes No
Standard: Yes No

Standard walker: Yes No

Walker with wheels: Yes No

Platform attachment: Yes No

Hospital bed: Yes No

Other: _____

A Rx should accompany each order.

Physician's Signature: _____ Date: _____

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