CHOICE medical equipment
1173 Bent Oaks Dr, Denton, TX, 76210
(PH) 940-380-0455
(FX) 940-382-3026

DETAILED WRITTEN ORDER

Patient:_____DOB:_____Date:_____
Address: _____Phone:_____
Estimated LON: 99 Months (Lifetime) unless otherwise specified:___ Height:_____Weight:_____

PATIENT DIAGNOSIS (ICD-10) – AT LEAST ONE MUST BE CHECKED

☐ I50.20 CHF Systolic Failure	☐ J44.9 COPD	☐ M62.81 Muscle Weakness	☐ R09.02 Hypoxemia
☐ I50.30 CHF Diastolic Failure	☐ G47.33 OSA	☐ R26.2 Difficulty Walking	☐ Z93.3 Colostomy
☐ I50.40 CHF Combined Failure	☐ J45.901 Asthma	☐ G89.4 Chronic Pain	☐ J43.9 Emphysema
☐ I63.9 Cerebral Infarction (CVA)	☐ R32 Urinary Incontinence	☐ R13.10 Dysphagia	☐ J40 Bronchitis
☐ E10.9 Type 1 Diabetes	☐ E11.9 Type 2 Diabetes	☐ Other_____	☐ Other_____

RESPIRATORY EQUIPMENT:

☐ Oxygen Concentrator (E1390) LPM: _____ Hrs/Day: _____ via Nasal Cannula
☐ Oxygen Portable System (E0431) Conserving Device Nocturnal Use Only Bleed in PAP
☐ Nebulizer Compressor (E0570) With Reusable Admin Set (A7005) With Disposable Admin Set Mask

SLEEP THERAPY:

☐ CPAP (E0601) _____cmH2O Ramp: _____
☐ CPAP - Auto Titrating (E0601) Min: _____cmH2O Max:_____cmH2O
☐ BIPAP (E0470) IPAP:_____cmH2O EPAP:_____cmH2O
☐ RAD with Backup (E0471) IPAP:_____cmH2O EPAP:_____cmH2O Rate:_____

☐ Heated Humidifier (E0562)	☐ Chinstrap – 1 per 6 mo (A7036)	☐ H2O Chamber – 1 per 6 mo (A7046)
☐ Full Face Mask – 1 per 3 mo (A7030)	☐ Full Face Cushion – 1 per mo (A7031)	☐ Hybrid Mask – 1 per 3 mo (A7027)
☐ Nasal Mask – 1 per 3 mo (A7034)	☐ Nasal Pillows – 2 Pair per mo (A7033)	☐ Nasal Cushion – 2 per mo (A7032)
☐ Tubing – 1 per 3 mo (A7037)	☐ Climate Line – 1 per 3 mos (A4604)	☐ Headgear – 1 per 6 mos (A7035)
☐ Filter: Non Disp – 1 per mo (A7039)	☐ Filter: Disp – 2 per mo (A7038)	

WHEELCHAIR & ACCESSORIES:

☐ Standard (K0001)	☐ High Strength Lightweight (K0004)	☐ Elevating Leg Rests (K0195)
☐ Lightweight (K0003)	☐ Heavy Duty (K0006)	☐ Anti-Tippers (E0971)
☐ Foot Rests/Heel Loops (E0951)	☐ Extra Seat Width (E2201)	☐ General Seat (E2601) & Back Cushion (E2611)

☐ Additional Form Required for: Skin Protection Cushions

HOSPITAL BED & ACCESSORIES:

☐ Semi-Electric (E0260) ☐ Patient Lift (E0630) ☐ Trapeze (E0910)
☐ Additional Form Required for: Pressure Reducing Mattress and Gel Mattress Overlay

AMBULATORY AIDS:

☐ Walker – Folding (E0135)	☐ Walker Heavy Duty with Wheels (E0149)	☐ Quad Cane (E0105)
☐ Walker – Folding with Wheels (E0143)	☐ Walker Heavy Duty with Brakes (E0147)	☐ Cane (E0100)
☐ Walker – Rollator (E0143 & E0156)	☐ Bedside Commode (E0163)	☐ Shower Chair (Private Pay)
☐ Walker – Heavy Duty (E0148)	☐ Crutches (e0114)	☐ Tub Transfer Bench (Private Pay)

☐ **OTHER: (PLEASE SPECIFY)** _____

PLEASE ATTACH THE FOLLOWING AS APPLICABLE:

☐ Test Results (Oximetry, ABG, Sleep Study) ☐ Patient Demographics Sheet ☐ Copy of Patient's Insurance Card
☐ Physician's Notes - Notes from the patient's medical record documenting face-to-face equipment needs assessment and expected benefit from equipment ordered above.

PHYSICIAN INFORMATION:

Name:_____ NPI:_____ Phone: _____
Address: _____ Fax:_____

Physician Signature:✖_____ Date: ✖_____