Diamond Medical Equipment
Office: (480) 926-4363
Fax: (480) 926-4364

Detailed Written Order

Date: _________

Patient name: ________________________ DOB: ___________ Height_____ Weight_______

Length of need: ___________ (if lifetime, use 99months) Start Date:___________

DURABLE MEDICAL EQUIPMENT

Wheelchair: **Diagnosis:** _________ **Diagnosis:** _________

☐ Hemi Height Wheelchair ☐ Light Weight Wheelchair ☐ Heavy Duty Wheelchair
☐ Standard Wheelchair ☐ Fully Reclining Back ☐ Extra Heavy Duty Wheelchair
☐ General Seat Cushion ☐ General Back Cushion ☐ Elevated leg rest
☐ Pressure Relief/Skin Protection Cushion ☐ 20” ☐ 18” ☐ 16” ☐ 22” ☐ 24”

Walker: **Diagnosis:** __________ **Diagnosis:** _________

☐ Front Wheeled Walker ☐ Four Wheeled Walker with Seat Attachment
☐ Heavy Duty Front Wheeled Walker

Semi Electric Hospital Bed: **Diagnosis:** __________ **Diagnosis:** _________

☐ Semi-Electric Hospital Bed ☐ Bariatric Semi-Electric Hospital Bed ☐ Gel Overlay
☐ APP&P ☐ Low loss air mattress

Respiratory Services

Diagnosis:
☐ COPD (496.) ☐ Extrinsic Asthma (493.00) ☐ OSA (327.23) ☐ Acute Bronchiolitis (466.0)
☐ Chronic Obstructive Asthma (4393.20) ☐ Emphysema (492.0)
☐ CHF (428.0) ☐ Chronic Bronchitis (491.20) ☐ Other: _______________

Oxygen

☐ Home Oxygen LPM___________ via ☐ NC ☐ Continuous ☐ Nocturnal ☐ w/ portable
Test Results: Pulse Oximetry/SaO2_________________ ABG/PaO2: ___________________
Date Tested: ________ Where Tested: ______________ ☐ Inpatient facility ☐ OutPatient
Test Condition: ☐ Nocturnal ______ ☐ Rest ______ ☐ Exertion______ ☐ Exertion______OnO2

PAP Services

☐ CPAP _________ cm/H2O BiPAP_________cm/H2O ☐ Heated Humidifier
☐ Nasal mask ☐ Full Face Mask ☐ Nasal Pillows ☐ Head gear ☐ Cushions
☐ Chin Strap ☐ Tubing ☐ Heated tubing Filters: ☐ Disposable ☐ Reusable

Eternal Feedings

☐ Formula_________ Total cal/day___________ Frequency _____________ ☐ Dysphagia
☐ Large Volume Pump ☐ IV Pole ☐ Supply kit-syringe feed ☐ Supply kit-pump feed

Other

☐ Commode ☐ Heavy Duty Commode ☐ Patient lift ☐ Arm trough

Comments/Other orders:

(Please provide face-to-face chart notes that support medical necessity with the order)

I hereby certify that the services are medically necessary and are authorized by me. The patient is under my care and is in need of the services listed above.

Physician’s Signature: Date: Fax:

Physician’s Printed Name NPI Number