Diamond Medical Equipment
Office: (480) 926-4363
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Detailed Written Order

Patient name: _____ DOB: _____ Date _____

Length of need: _____ Height_____ Weight_____ Start/Discharge Date:_____

Diagnosis: _____ **Diagnosis:** _____ **Diagnosis:** _____ **Diagnosis:** _____

DURABLE MEDICAL EQUIPMENT

Wheelchair: ☐ **18"** ☐ **16"** Nonstandard Seat Frame Width : ☐ **24"** ☐ **22"** ☐ **20"**

☐ Hemi Height Wheelchair(<65") ☐ Light Weight Wheelchair ☐ Heavy Duty Wheelchair(250)
☐ Standard Wheelchair ☐ Fully Reclining Back ☐ Extra Heavy Duty Wheelchair(300)
☐ General Seat Cushion ☐ General Back Cushion ☐ Elevated leg rest
☐ Arm trough ☐ Anti Tippers ☐ Pressure Relief/Skin Protection Cushion

Walker:

☐ Front Wheeled Walker ☐ Four Wheeled Walker with Seat Attachment
☐ Hemi Walker ☐ Platform Left or Right (circle) ☐ Heavy Duty Front Wheeled Walker

Semi Electric Hospital Bed:

☐ Semi-Electric Hospital Bed (<350) ☐ Bariatric Semi-Electric Hospital Bed (350-600)
☐ APP&P (Group I) ☐ Gel Overlay (Group I) ☐ Low loss air mattress (Group II)

Oxygen (CMN is also required)

☐ Home Oxygen LPM_____ via ☐ NC ☐ Continuous ☐ Portable w/contents ☐ Nocturnal
Date Tested: _____ Where Tested: _____ ☐ Inpatient facility ☐ OutPatient
Continuous Test Condition: **RA** Rest _____ **RA** Exertion_____ Exertion _____ On_____/LPMO2
Nocturnal Test Condition: Nocturnal _____ (test equipment print out required)

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

Enteral Feedings

☐ Formula_____ Frequency _____ Total cal/day _____ via a tube into the stomach ☐ Large Volume Pump ☐ IV Pole ☐ Supply kit- **pump** feed ☐ Supply kit- **syringe** feed

Other

☐ Patient lift w/sling ☐ SVN Machine (nebulizer) Rx _____

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: _____

Physician's Printed Name _____ NPI # _____

Items needed to dispense MEDICARE DME. DIAMOND MEDICAL EQUIP.

_____Detailed Written Order (DWO)
_____Face Sheet – Demographics sheet
_____Progress note with face to face evaluation for Durable Medical Equipment
_____Copy of Insurance Card

Progress Note Language needed for Wheelchairs

_____has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home.
_____mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker.
_____home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided.
_____will significantly improve the beneficiary's ability to participate in MRADLs and the beneficiary will use it on a regular basis in the home.
_____The beneficiary has not expressed an unwillingness to use the manual wheelchair that is provided in the home.
_____The beneficiary has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function
_____OR, The beneficiary has a caregiver who is available, willing, and able to provide assistance with the wheelchair.

For Nonstandard Wheelchair Widths (20" or larger)

_____ requires nonstandard seat frame width due to patient's hip width

For a Hemi Ht wheelchair Pt is 5'6" or shorter ADD

_____ beneficiary requires a lower seat height (17" to 18") because of short stature or to enable the beneficiary to place his/her feet on the ground for propulsion.

For Light weight wheelchair ADD

_____Cannot self-propel in a standard wheelchair in the home; can and does self-propel in a lightweight wheelchair.

For Heavy Duty ADD _____ Pts weight is over 250lbs**. For Extra Heavy Duty ADD** _____ Pts weight is over 300 LBS
_____For Reclining back ADD. ____ Pt Can NOT pressure relieve himself, or ____ Pt self-catheterizes.

Progress Note Language needed for Semi Electric Hospital Bed

_____ has a medical condition which requires positioning of the body in ways not feasible with an ordinary bed.
_____ The beneficiary requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration
_____ requires frequent changes in body position and/or has an immediate need for a change in body position due to _____
_____Severity of condition while is ordinary bed.

Progress Note Language Needed for Home Oxygen

_____Room air sats are 88% or lower at rest. **OR** ___RA sat at rest___RA sat at exertion___Sat w O2 (48hr prior DC)
_____Has an underlying lung disease (ie COPD)
_____Medical condition causes hypoxic symptoms and would benefit from oxygen therapies.
_____Certificate of Medical Necessity (CMN)

Progress Note Language Needed for Low Air Loss Mattress

_____Patient has multiple stage II ulcers on the trunk or pelvis, or_____has large stage III or IV ulcer on trunk or pelvis
_____Group 2 form and skin assessment

Progress Note Language Needed for CPAP

_____OSA assessment with HTN, CVA, sleepiness, insomnia, mood disorder, impaired cognition
_____Steep Study Report _____Titration Report _____Physician Follow up

Progress Note Language for Enteral Feedings

_____ permanent non-function or disease of the structures that normally permit food to reach the small bowel
_____ tube feedings to provide sufficient nutrients to maintain weight and strength commensurate with the beneficiary's overall health status through a tube into the stomach
For a pump_____aspiration____severe diarrhea___dumping syndrome___administration rate less than 100 ml/hr___blood glucose fluctuations___circulatory overload___gastrostomy/jejunostomy tube used for feeding