RT Medical - Jenny: 615-469-7299 ext 114

RT Medical Fax: 615-469-7596

Order Date: ______________________________

STEP 1 | Physician Information

Physician Name ______________________________

Physician Signature ___________________________

NPI # ________________________________

Date _________________________________

Facility Name _____________________________

Form Completed By __________________________

Phone Number ____________________________

STEP 2 | Patient Information

Patient Name ______________________________

Patient DOB ______________________________

Patient Phone Number _______________________

Patient E-Mail ____________________________

STEP 3 | Diagnosis

___Primary: ___________________ ___Secondary:____________________ ___Other: ____________

STEP 4 | DME Prescription

Mobility/Bed

__Walker __Wheelchair __Low Air Loss Mattress __Alternating Pressure Pad __Gel Overlay

__Patient Lift __Hospital Bed __Bedside Commode

Enteral

__Feeding Pump __ Formula _________________________ Frequency/Volume____________________

Length of Need

Please note: this information is required.

Length of need: ________months (99=lifetime)

Patient Questions:

1. Has this patient had this equipment before? Yes__ No__
2. Is this patient room/bed bound? Yes__ No__
3. Is the patient's bathroom located on a floor they can access? Yes__ No__

Notes:

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STEP 5 | FAX

Fax this form and patient demographic sheet which includes insurance information to RT Medical.