Doctor's Choice
Home Medical Equipment

- EASY FAX WRITTEN ORDER FORM -

OFFICE: (312) 666-1111 ⬩ WWW.NUWAY-DISTRIBUTORS.COM ⬩ MBE CERTIFIED

PHYSICIAN INFORMATION	NAME/ADDRESS/PHONE: TELEPHONE: ( ) FAX: ( )	
	LICENSE NO:	NPI NO:

THANK YOU FOR YOUR REFERRAL!

PLEASE FAX YOUR REQUEST TO:

(312) 666-1121

EMAIL ORDERS TO:
ALEX@DOCTORSCHOICEHME.COM

REFERRAL NAME: PHONE: **Date:**

PATIENT NAME:		DATE OF BIRTH:	HOME TELEPHONE NO:
STREET ADDRESS:		CITY/STATE/ZIP CODE:	
SOCIAL SECURITY NO:	HT:	WT:	GENDER: ❒ Male ❒ Female
PRIMARY INSURANCE:	SUBSCRIBER ID:		**DIAGNOSIS (ICD-10 CODES):**
SECONDARY INSURANCE:	SUBSCRIBER ID:	EQUIPMENT LENGTH OF NEED: (99 MONTHS = LIFETIME NEED) 99 MONTHS	

Please check ☑ all items being ordered for the patient named above. Fax all correspondence to **(312) 666-1121**.
All items marked with an asterisk (*) require additional documentation and is needed prior to delivery of equipment.

RESPIRATORY EQUIPMENT

- ❒ Oxygen at ________ LPM **(*)**
  - ❒ Continuous
  - ❒ PRN (As Needed)
  - ❒ Nocturnal Use
- Date of Test: ________________
  - SAT Level: ______ %
  - Blood Gas: ______ mmHg
- ❒ Nebulizer Compressor Unit
  - ❒ Neb Kits Supplies
  - ❒ Neb Adult Mask
- ❒ Other (Please list below):

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DURABLE MEDICAL EQUIPMENT / OTHER ITEMS

- ❒ 3-in-1 Bedside Commode
- ❒ Straight Cane
- ❒ Quad Cane
- ❒ Raised Toilet Seat
- ❒ Shower Chair
- ❒ Bathtub Transfer Bench
- ❒ Rollator Walker [With handbrakes & seat]
- ❒ Adult Walker
  - ❒ NO WHEELS
  - ❒ WITH WHEELS
- ❒ Blood Pressure Monitor
- ❒ **Other** (Please list below):
- ❒ Hospital Bed (w/ mattress) *
- ❒ Patient Lift / Hoyer Lift
- ❒ Standard Manual Wheelchair*
- ❒ Heavy Duty Manual Wheelchair*
  - ❒ FOOTRESTS
  - ❒ ELEVATING LEG RESTS
- ❒ Incontinence Supplies
  - ❒ Underwear – Monthly Supp
  - ❒ Diapers – Monthly Supp
  - ❒ Pant Liners – Monthly Supp
  - ❒ Chux – Monthly Supp
- ❒ Wrist Brace
  - ❒ Left
  - ❒ Right
- ❒ Back Brace

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PHYSICIAN SIGNATURE: ______________________________ DATE OF SIGNATURE: ____________________

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