



WESTERN DRUG MEDICAL SUPPLY

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Patient Name _____ DOB _____

Pt Home Address _____ Tel. _____

Insurance M/Care M/Cal Other _____ Referring MD _____

ID # _____ Height _____ Weight _____

Diagnosis COPD CHF OSA Diabetes Mellitus (IDDM) Osteoarthritis

Osteoporosis CVA Myocardial Infarction Hip Fracture Other _____

EQUIPMENT

Gait Device L.O.N. _____

- FWW
- 4WW
- SPC
- WBQC/NBQC

Wheelchair L.O.N. _____

- Standard Weight Foam Cushion
- Lightweight Gel Cushion
- Hemi Height Roho Cushion
- Elevating Leg Rests Back Cushion
- Other _____

Bathroom Equipment L.O.N. _____

- Tub Transfer Bench
- Shower Chair
- All in 1 Commode
- Raised Toilet Seat

Custom Wheelchairs L.O.N. _____

- High Strength Ultra Lightweight
- Power Wheelchair
- Power Scooter

Hospital Bed L.O.N. _____

- Semi Electric Fully Electric
 - Full Rails
 - Half Rails
- Mattress
- Get Overlay
- Alternating Pressure Pad
- Low Air Loss Mattress
- Overhead Trapeze Bar
- Other _____

Respiratory L.O.N. _____

- Oxygen @ _____ LPM via nasal Canula
- Continuous
- Nocturnal Only

* PLEASE PROVIDE OXYGEN TEST RESULTS *

- Nebulizer w/Neb Cup Medications: _____
Frequency: _____
- Nebulizer Mask

Diabetic Supplies

- Glucometer
- Strips Qty: 100 Other _____
- Lancets Qty: 100 Other _____

Sleep Equipment L.O.N. _____

- CPAP AUTO CPAP BiPAP
- BiPAP w/Backup Rate Auto BiPAP
- Heated Humidifier
- Settings: _____

Incontinence Supplies

- Diapers
- Underpads

Sleep Study

- Diagnostic Sleep Study Sleep Study w/CPAP titration

Physician's Signature: _____ Date: _____