

HPSJ ORDER FORM

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PATIENT DEMOGRAPHICS

Patient Name: _____ **DOB:** _____ **Gender:** ____ M ____ F
Phone: _____
Insurance: _____ **Policy ID:** _____
Diagnosis (ICD 10) : _____

GAIT DEVICES

____ FRONT WHEELED WALKER
____ 4 WHEELED WALKER
____ 4 WHEELED WALKER W/ SEAT
____ SPC
____ WBQC/NBQC

WHEELCHAIRS

____ STANDARD WEIGHT
____ LIGHTWEIGHT
____ HEMI HEIGHT
____ ELEVATING LEG RESTS
____ OTHER: _____

POWER & CUSTOM WHEELCHAIRS

____ HIGH STRENGTH ULTRA
LIGHTWEIGHT
____ POWER WHEELCHAIR
____ POWER SCOOTER

BATHROOM EQUIPMENT

____ TUB TRANSFER BENCH
____ SHOWER CHAIR
____ ALL IN 1 COMMODE
____ RAISED TOILET SEAT

CUSHIONS

____ FOAM CUSHION
____ GEL CUSHION
____ ROHO CUSHION
____ BACK CUSHION

NEBULIZER

____ NEBULIZER WITH NEB CUP
____ NEBULIZER MASK

MEDICATIONS _____
FREQUENCY _____

HOSPITAL BED

____ SEMI ELECTRIC ____ FULLY ELECTRIC
____ FULL RAILS
____ HALF RAILS

SUPPORT SURFACES

____ GEL OVERLAY
____ ALTERNATING PRESSURE PAD
____ LOW AIR LOSS MATTRESS
____ OVERHEAD TRAPEZE BAR
____ OTHER: _____

BREAST PUMP

____ ELECTRIC
____ HOSPITAL GRADE

Flange Size:

____ Small (19mm / 21mm)
____ Medium (25mm - Standard)
____ Large (28.5mm / 30.5mm)

NOTES:

****ALL ITEMS WILL BE DISPENSED PER GUIDELINES/ALLOWABLES UNLESS CLINICAL JUSTIFICATION IS PROVIDED FOR AMOUNTS GREATER THAN GUIDELINES/ALLOWABLES****

Physician Name: _____ **NPI:** _____
Phone: _____ **Fax:** _____
Physician Signature: _____ **Date:** _____