AXIOS
MEDICAL EQUIPMENT

PHONE: 312-738-2330
FAX: 312-738-2395

DME Written Order Prior to Delivery

PATIENT NAME:_____ ORDER DATE:_____
PATIENT D.O.B:_____ SSN / MEDICARE #:_____ DISCHARGE DATE:_____
HEIGHT:_____ WEIGHT:_____ PHONE NUMBER:_____ LENGTH OF NEED: 99

WHEELCHAIR TYPE

☐ *LIGHTWEIGHT*(K0003) - QTY:1(ADJUSTABLE HEIGHT ARMS(E0973) QTY:2, ANTI-TIPPERS(E0971) QTY:2, WHEEL LOCK EXTENSIONS(E0961) QTY:2, HEEL LOOPS(E0951) QTY:2)
☐ 16" LIGHTWEIGHT ☐ 18" LIGHTWEIGHT ☐ 20" LIGHTWEIGHT & NON-STANDARD SEAT FRAME(E2201) - PATIENTS HIP MEASUREMENT EXCEEDS 19"

☐ *22" HEAVY DUTY(K0006)* - QTY:1(NON STANDARD SEAT FRAME (E2201) PATIENT'S HIP MEASUREMENT EXCEEDS 19", QTY:1, ANTI-TIPPERS(E0971) QTY:2, WHEEL LOCK EXTENSIONS(E0961) QTY:2, HEEL LOOPS(E0951) QTY:2

☐ *24" HEAVY DUTY(K0007)* - QTY:1(NON STANDARD SEAT FRAME (E2202) PATIENT'S HIP MEASUREMENT EXCEEDS 22", QTY:1, ANTI-TIPPERS(E0971) QTY:2, WHEEL LOCK EXTENSIONS(E0961) QTY:2, HEEL LOOPS(E0951) QTY:2

☐ *RECLINING WHEELCHAIR*(K0001) - QTY:1(MANUAL RECLINING BACK(E1226) QTY:1, ANTI-TIPPERS(E0971) QTY:2, HEAD REST(E0955), ELEVATING LEG REST(K0195), QTY:2
☐ 16" RECLINING ☐ 18" RECLINING ☐ 20" RECLINING & NON-STANDARD SEAT FRAME(E2201) - PATIENTS HIP MEASUREMENT EXCEEDS 19"

CUSHIONS

☐ *BACK SUPPORT CUSHION(E2611)/(E2612)*
☐ *SEAT CUSHION - GENERAL USE* (E2601)/(E2602)
☐ *SKIN PROTECTION CUSHION* (E2622)/(E2623)

WHEELCHAIR ACCESSORIES

☐ TRANSFER BOARD (E0705) Qty:1
☐ LOWERED SEAT HEIGHT TO 17" (K0056)
☐ WHEELCHAIR POSITIONING/SEAT BELT (E0978) Qty:1
☐ *ARM TROUGH* (E2209) Qty:1 ☐ LEFT ☐ RIGHT
☐ ELEVATING LEG RESTS (K0195) Qty:1
☐ OXYGEN TANK CARRIER (E2208) Qty:1
☐ ARTICULATING LEG RESTS (K0053) Qty:1
☐ RESIDUAL LIMB SUPPORT (E1020) Qty:1
☐ LEFT ☐ RIGHT

HOSPITAL BED AND ACCESSORIES

☐ *HOSPITAL BED* QTY:1
☐ HALF RAILS ☐ FULL RAILS ☐ NO RAILS
☐ *TRAPEZE* - (250LB MAX) - (E0910/A9900) QTY:1

☐ *HOYER/PATIENT LIFT* (E0630) QTY:1
HOYER SLING TYPE
☐ FULL BODY SOLID
☐ MESH WITH COMMODE OPENING
HOYER SLING SIZE
☐ MEDIUM
☐ LARGE
☐ EXTRA LARGE

PRESSURE ULCER PREVENTION AND TREATMENT

☐ *GEL FOAM OVERLAY MATTRESS* (E0185) QTY: 1

☐ COMPLETELY IMMOBILE *OR*

CHECK ONE:	*AND* (CHECK AT LEAST ONE):
☐ LIMITED MOBILITY *OR* ☐ ANY PRESSURE ULCER ON TRUNK OR PELVIS	☐ A. IMPAIRED NUTRITIONAL STATUS ☐ B. FECAL OR URINARY INCONTINENCE ☐ C. ALTERED SENSORY PERCEPTION ☐ D .COMPROMISED CIRCULATORY STATUS

☐ *LOW AIR LOSS MATTRESS WITH ALTERNATING PRESSURE THERAPY (E0277) QTY:1*

COMMODES

☐ *3-IN-1 FOLDING COMMODE* - (E0163) QTY:1
☐ *3-IN-1 DROP ARM COMMODE* - (E0165) QTY:1

TWO-WHEELED WALKERS

☐ *STANDARD WALKER* (E0143) QTY:1
☐ *JUNIOR WALKER* (E0143[2]) QTY:1
☐ *WALKER WITH A SEAT* (E0143 & E0156) QTY:1

FOUR-WHEELED WALKERS

☐ *ROLLATOR WALKER* (E0143) QTY:1, WALKER SEAT ATTACHMENT (E0156) QTY:1, BRAKE ATTACHMENT (E0159) QTY : 2
$50 UPGRADE FEE

☐ *UPRIGHT ROLLATOR WALKER* (E0143) QTY:1, PLATFORM ATTACHMENT (E0154) QTY:2, WALKER SEAT ATTACHMENT E0156 QTY:1, WALKER BRAKE ATTACHEMENT (E 159) QTY:2
$200 UPGRADE FEE

I certify that this patient is under my care and that I, a Nurse Practitioner, or Physician's Assistant working with me, and had a face to face encounter that meets the physician face to face encounter requirements with this patient.

PHYSICIAN NAME:_____ NPI #:_____

PHYSICIAN SIGNATURE:_____ DATE:_____

Note: Please maintain a copy of the Written Order, which must be kept on file for 7 years or longer if, required by state law.

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