Connect DME

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FAX TO: (918) 515-6171

Physician Name: _____

NPI #: _____ Phone: _____

Patient Name: _____ DOB: _____

Phone: _____ Email: _____

Address: _____ City: _____ State/ZIP: _____

KNEE BRACING:
- ☐ Hinged knee brace
- ☐ Post-OP ROM brace
- ☐ Knee Immobilizer
- ☐ Custom ligament brace*

ANKLE:
- ☐ Pneumatic walking boot
- ☐ Pneumatic walking boot ROM
- ☐ Ankle pneumatic walking boot
- ☐ Ankle pneumatic walking boot ROM
- ☐ Ankle brace w/stirrup
- ☐ Ankle brace lace up

BACK:
- ☐ Back brace LO
- ☐ Back brace LSO*
- ☐ Back brace LSO w/lateral panels*

NECK:
- ☐ Cervical Soft collar
- ☐ Cervical Ridge collar

UPPER EXTREMITY
- ☐ Shoulder sling w/abduction pillow
- ☐ Shoulder immobilizer
- ☐ Arm sling
- ☐ Universal wrist splint
- ☐ Elbow brace with hinges
- ☐ Thumb wrist splint

SUPPORTS:
- ☐ Crutches
- ☐ Heavy duty crutches
- ☐ Walker
- ☐ Heavy duty walker
- ☐ Walker w/wheels
- ☐ Heavy duty walker w/wheels
- ☐ Cane
- ☐ Toilet seat with arms
- ☐ Commode

* Pre-Authorization Required

RESPIRATORY:
- ☐ C-PAP*
- ☐ C-PAP w/Humidifier *
- ☐ Bi-PAP*
- ☐ Bi-PAP w/Humidifier*
- ☐ Nebulizer

THERAPIES:
- ☐ TENS electro therapy stem
- ☐ 4 lead electro therapy
- ☐ Bone growth stimulator
- ☐ Pneumatic DVT Prevention
- ☐ Cold therapy
- ☐ Heat therapy
- ☐ Cervical traction
- ☐ Knee CPM machine
- ☐ Shoulder CPM machine *
- ☐ Lymphedema pump *
- ☐ Ted Hose
- ☐ INR/PT Home Test Kit*

ADDITIONAL PRODUCTS:

I certify that I am the physician identified in this form. I have reviewed the Detailed Written Order. Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in is true, accurate and complete to the best of my knowledge. I certify that the patient/caregiver is capable and has successfully completed or will be trained on the proper use of products prescribed on this Written Order. The products lists and physician notes and other supporting documentation will be provided to DME and/or an authorized distributor upon request. I acknowledging that the patient is aware that DME and/or an authorized distributor may contact them for any additional information to process this order. A copy of this order will be retained as part of the patient's medical record.

X_____ X_____/_____

Physician Signature Date Printed Name