1934 Newmark St
North Bend, OR 97459
Phone: 541-756-9016
Fax: 541-673-0715

DURABLE MEDICAL EQUIPMENT PRESCRIPTION

NAME:____ **DOB:**______________________

ADDRESS:____ **PHONE:**_______________________

ICD-10 Code: ____________________(Required) **LENGTH OF NEED:** __________ **Months** (Required)

DIABETIC SUPPLIES: ***NON-INSULIN DEPENDENT**(ONCE PER DAY) INSULIN DEPENDENT**(THREE TIMES PER DAY)***

*****PLEASE FAX CHART NOTES IF ABOVE GUIDELINE TESTING*****

MEMBER IS TO TEST: _____________ **PER DAY** **INSULIN INJECTIONS:** _____________**PER DAY**

	QTY		
TEST STRIPS 50/box	/month	**LANCING DEVICE**	
LANCETS 100/box	/month	**CONTROL SOLUTION**	
ALCOHOL WIPES 100/box	/month	**REPLACEMENT BATTERY**	
PEN NEEDLES 100/box	/month		
SYRINGES 100/box	/month		

INCONTINENT SUPPLIES

***BRIEFS** (Tape- on) ________	***PULLUPS** (Underwear) ________	***LINERS** ________	***ANY COMBO 200 PER MONTH**
DISPOSABLE UNDERPADS (Chux) (100 PER MO)	**OR**	**WASHABLE UNDERPADS (8 PER YR)**	
GLOVES (2 BOXES PER MO)	**SM:**	**MED:**	**LG:**

MISC SUPPLY (Check supply)

NEBULIZER	**NEB MASK**	**NEB FILTERS**	
SPACER	**DISP. NEB CUP KIT**	**PEAK FLOW METER**	
AUTOMATIC BLOOD PRESSURE MONITOR			

PRESCRIBING PHYSICIAN: ____________________________________ **Fax#:**______________

SIGNATURE: _______________________________________ **DATE:** ____________________