RICK'S MEDICAL SUPPLY

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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		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	/daily		
SYRINGES 100/box	/daily		

INCONTINENT SUPPLIES (Please list quantity and size)

***BRIEFS** (Tape- on) Qty:_____ Size:_____	***PULLUPS** (Underwear) Qty:_____ Size:_____	***LINERS** Qty:_____	***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)

				QTY
NEBULIZER ☐	**NEBULIZER MASK** ☐	**DISP. NEB CUP KIT** ☐		
SPACER ☐	**SPACER WITH MASK** ☐	**PEAK FLOW METER** ☐		
AUTOMATIC BLOOD PRESSURE MONITOR ☐	**Cuff Size:** ☐ Pediatric	☐ Regular	☐ Bariatric	

PRESCRIBING PHYSICIAN: _____ **Fax#:**_____

SIGNATURE: _____ **DATE:** _____