



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: _____