Intermountain Health

Home Medical Equipment Order

Phone: 385-887-6766 Fax: 801-442-0709

PATIENT INFORMATION

Patient Name: _____ DOB: _____

Address: _____

Phone #1: _____ Phone #2: _____

Primary Ins: _____ Secondary Ins: _____

Diagnosis: _____

Equipment Needed:

☐ **Oxygen:** Length of Need (LON): _____months [99=lifetime]
LPM_____ Room air Sat:_____% Date Taken_____ ☐ Nocturnal ☐ Continuous
☐ Concentrator ☐ O_2 Conserver System ☐ Portable ☐ Other_____

☐ **Pulse Oximeter:** Length of Need_____

Check One:	**Check Any:**	**Check One:**
☐ Overnight	☐ On Room Air	☐ No Alarm
☐ >1 day	☐ O2 at _____ lpm	☐Set Alarm at _____%
☐ Continuous weekly	☐ CPAP at _____cm	
☐ Continuous monthly.	☐ SAT High_____ Low _____	

☐ **Nebulizer:** LON_____

☐ **Suction Machine with**_____ LON_____

☐ **Apnea Monitor:** Apnea Delay_____; HR low:_____bpm; HR high:_____bpm LON:_____

☐ **Phototherapy:** ☐ Blanket ☐Bed ☐Bilisoft Bilirubin Level_____ LON:_____

Height_____ Weight_____

☐ **Walker:** (Length of Need: _____ months) ☐ Front Wheeled Walker ☐ Four Wheeled Walker with seat

☐ **Crutches:** ☐ Axillary Crutches (standard) ☐ Forearm Crutches (standard)
☐ Forearm Crutches (walk easy)

☐ **CPM:** *Settings from*_____ *to* _____ ☐ Knee

☐ **Hospital Bed:** (Length of Need: __ months)
☐ _____ % of time in bed per day ☐ Unable to reposition self in bed
☐ Existing wounds ☐ Requires HOB elevation @ _____

☐ **Wheelchair:** Type_____ (LON: _____ months) ☐Leg Rest: ☐ Standard ☐ Elevating

☐ **Knee Walker:** (Length of Need: _____ months)

☐ **Other item:**

(Length of Need: ___ months)

Provider's Name: (Please Print) _____ NPI #: _____

Provider's Signature: _____ Date: _____

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