



Asbury Medical Supply
"For all your home medical needs"

Fax Order To: **(405) 858-0119**

or
 Call In: **(405) 858-0097**

DME – Physician's Order
Durable Medical Equipment

Patient Name: _____	Date of Birth: _____	Phone Number: _____
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Diagnosis: _____ Patient's Height _____
 Length of Need (in months 99=Lifetime) _____ Patient's Weight _____

Equipment Request

- Wheelchair Standard Light-Weight Recline 1arm Drive **L** or **R** Elevating Legrest **L R Both**
- Cushion General Use or Other Type _____
- Walker Standard with wheels **3in** or **5in** Platform **L** or **R** Hemi-walker (side step)
- 4-Wheeled Walker with Seat Attachment
- Cane quad regular Crutches
- Hospital Bed half-length rails full-length rails Trapeze Bar
- Wound Care Therapy Support Surface Group 1 overlay **Air** or **Gel** Group 2 mattress
- Bedside Commode Standard Heavy-Duty Drop Arm
- Tub Transfer Bench Standard Heavy-Duty Padded
- Shower Chair with back or without back [] Check here for Heavy-Duty (>400 lbs)
- Raised Toilet Seat with arms or without arms Toilet Safety Frame

Respiratory

- Oxygen _____LPM _____ SpO₂/PaO₂ Date of Test: _____
- Overnight Pulse Oximetry (O₂ Sat Test)
- Nebulizer / Compressor
- CPAP _____cm H₂O **Sleep study required for CPAP and BiPAP.**
- BiPAP _____ IPAP _____ EPAP

Other _____

Special Instructions / Orders: _____

Physician Signature: _____	Phone Number: _____	UPIN: _____
Physician Name: _____	Date: _____	Order Sent to Asbury Medical By: _____