PROVIDENCE HOME MEDICAL EQUIPMENT		HME Prescription Referral Form	PROVIDENCE Health & Services
6410 NE Halsey, Suite 500 Portland, OR 97213 Phone: (503) 215-4663 Fax: (503) 215-4655	**Salem Location:** 2508 Pringle Road Salem, OR 97302 Phone: (503) 585-4027		

Date:	**Ordering Contact:**	**Phone #:**	**Fax #:**

PATIENT DEMOGRAPHICS

Patient Name:	**DOB:**	**Primary Phone #:**	
Address:	**Apt. #:**	**City/State/Zip:**	
Alternate Contact/Relationship:		**Alt. Phone #:**	
Primary Insurance Plan:	**Ins. ID#:**		**Group #:**
Secondary Insurance Plan:	**Ins. ID#:**		**Group #:**
Subscriber Name:	**Relationship to Patient:**		**Subs. DOB:**
Primary Care Physician (if diff.):		**Phone #:**	**Fax#:**

PRESCRIPTION ORDERS

Length of Need: ☐ Life Time ☐ Other:	**Ht.:** in.	**Wt.:** lb.	**ICD-10 Code(s):**

☐ **Wheelchair** ☐ Footrests or ☐ Elevating Leg Rests *Type:* ☐ Heavy Duty w/ Wide Seat (wt. > 250 lbs.) ☐ Reclining Back

or ☐ **Walker** ☐ Front Wheel Walker (5" wheels) *Sizes:* ☐ Junior ☐ Adult ☐ Heavy Duty (pt. wt. > 300lbs)
☐ Four Wheel Rollator Walker w/ Seat *Color:* ☐ Red ☐ Blue

➡ **Y ☐ N ☐ Does the patient have a mobility limitation that impairs their ability to perform one or more mobility-related activities of daily living (toileting, grooming, and dressing) in customary locations in the home?**

☐ **Hospital Bed with Bed Rails**: ☐ Half ☐ Full ☐ None Trapeze Attachment: ☐ Egg Crate Bed Overlay: ☐

Y ☐ N ☐ Does the patient require frequent repositioning to alleviate pain and pressure points?

Y ☐ N ☐ Does the patient require the head of bed to be elevated greater than 30% due to CHF, COPD or aspiration risk?

☐ **Commode** ☐ Stationary, 3-in-1 ☐ Drop Arm ☐ Heavy Duty (pt. wt. > 300 lbs.)

Y ☐ N ☐ Patient is confined to single room? *or* **Y ☐ N ☐ patient is confined to floor/level with no bathroom?**

☐ **Patient Lift** ☐ U-Sling ☐ with Head Support *or*
☐ One-piece sling ☐ with Commode Opening

Sling Material/Size:
☐ Padded Polyester
☐ Nylon Mesh for bathing

☐ Small (55 – 110 lbs.)
☐ Medium (100 – 210 lbs.)
☐ Large (200 – 350 lbs.)

Y ☐ N ☐ Is the patient bed confined without the use of a lift for transfers to a wheelchair or commode?

☐ **Electric Breast Pump** *Estimated Delivery Date (EDC):* _____ *Diagnosis:* ☒ Z34.80 or: _____

☐ **Phototherapy for Neonatal Jaundice** *Length of Need:* ☐ 1 Week *or* ☐ Other: _____ *Diagnosis:* ☒ P59.9 or: _____

Bilirubin Levels: _____ mg/dl @ _____ hours old *Bilirubin Last Tested on Date:* _____ @ Time: _____

Other DME:

Comments:

[UNABLE TO FILL PATIENT'S PRESCRIPTION WITHOUT PHYSICIAN'S SIGNATURE AND DATE]

Physician Printed Name: **NPI#:**

➡ **Physician Signature: X** ➡ **Date:**

Please attach supporting documentation & fax to 503-215-4655

THANK YOU FOR CHOOSING PROVIDENCE HOME SERVICES