DME Plan of Care/Service/Supplies

Compression Garment:	Blood Glucose Monitor and Supplies:	Ambulatory:	Ostomy Supplies:
Manufacturer:___________ Leg:___Arm:____Other:______ (left or right) _______Compression _______Size	_______ glucose monitor _______ testing strips ________ lancets ________ control solution Testing frequency________	Cane:____straight _____4 prong Crutches: ____standard Crutches: ____forearm Walker:____2 wheel Walker: ______3-4 wheel Accessories________________ Instruction and fitting:________	____________________ ____________________ ____________________ **Urological Supplies:** ____________________ ____________________ ____________________
Orthosis Off the Shelf: Manufacturer _____________________ _________ right ________ left _________ size(s) **Hospital Beds, Mattresses, and other related equipment:** _________ caregiver _________ operating instructions	**Diabetic Shoes and Inserts:** manufacturer______________ size ______ **Nebulizers:** ___ proper fitting ___ instructions use/cleaning ___ supplies, mask, filters, tubing etc ___ practice using if needed	**Surgical Dressings:** ____________________ ____________________ ____________________ **Breast Prosthesis and Supplies:** ____________________ ____________________ ____________________	**Other Items:** ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________ ____________________

SAME OR SIMILAR	PRINT ALL THAT APPLY FROM HME AND OBTAIN SIGNATURES:
Does the patient have same or similar equipment? YES_____ No_______ If yes, previous provider_________________ Date purchased/rented__________________ Is patient now in a skilled nursing situation? YES_____ No_______ If yes, name of Facility__________________ Is the patient in the care of a nurse in the home? YES______ No_______	_______ *Advance Beneficiary Notice of Noncoverage (ABN) completed* _______ *Assignment of Benefits complete* _______*Rental Agreement* _______ Medical Necessity documentation _______Emergency Contact/Caregiver _______Medical Release authorization I HAVE BEEN GIVEN INSTRUCTION ON THE FOLLOWING: ______ Proper Use of Equipment ______Maintenance of Equipment ______Information on cleaning and infection control related to use of equipment ______Safety Hazards associated with equipment provided ______Manufacturer instructions if available

The patient will be provided the equipment/products to comply with the physician's prescription. The patient will use the equipment/products as prescribed by the physician. The patient will know how to obtain follow-up services as needed.

Patient's Name Printed_______________________________________ **Patient Code**______________

Signature of Patient (or person acting on patient's behalf)________________________________Date___________

Emergency Contact/Relationship to Patient: ☐ **I admit refusal to provide emergency contact information**

____Phone:____________________