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: ____Std crutches Crutches: ____forearm Walker: ______ 2 wheel Walker: ______3-4 wheel Accessories _______________ Fitting and instruction given______ (initial) ____________	________________ ________________ ________________ 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
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 ______

PRINT ALL THAT APPLY AND OBTAIN SIGNATURES:

_______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 ___________