Lake Region HOME MEDICAL SUPPLY

Physician Order for DME Supplies – Orthopedic

Acct: _____

Date of Order: ______________________________

Patient Name: ____ DOB: ______________________

Date of most recent Face to Face Examination: ____

Insert patient sticker, if available

Diagnosis and/or related Code(s): ____

Equipment/Supplies: **Quantity**

☐ Crutches

☐ Walker

☐ Knee Scooter

☐ Walking Boot

☐ Knee Brace

☐ Other: ____

Length of Need: ☐ 12 months ☐ Lifetime ☐ Other: ____________________

Physician Signature: ____ **Date:** ______________________

Physician Name: (please print) ______________________________ **NPI:** ______________________

Fax back to: 320-231-4941

Thank you for making Lake Region Home Medical Supply part of your healthcare team. Please call 218-332-5920 if any questions.