WessCare
Home Medical Equipment

Phone: (731) 836-1111
Fax: (731) 836-1006

Physician Order for Durable Medical Equipment

Patient Name:_____ Date Ordered:_____

Address: _____ City: _____

State: _____ Zip: _____ Phone: (_____)_____

Date of Last Visit: _____ Diagnosis Code(s):_____

_____ Standard Walker	___ Wheeled Walker	_____ Rollator	_____ Quad Cane
_____ Straight Cane	___ Lift Chair	_____ Wheelchair	_____ Electric Scooter
_____ Bed-Side Commode	___ Hospital Bed	_____ Seat Cushion	_____ Suction Machine
_____ Glucose Monitor	___ Monitoring Strips	_____ Tens Unit	_____ Enteral Feed
_____ Peak Flow Meters	___ CPAP/CFLEX	_____BiPAP/BiFLEX	_____ Pressure
_____Concentrator	___LPM	_____Heated Humidity	_____ Cool

_____ Nebulizer Other _____

Insurance Co. _____ PH # _____

ID# _____ DOB _____

Insurance Co. _____ PH# _____

ID# _____ DOB_____

_____ _____

Physician Signature UPIN #

___ Substitution allowed ___Dispense as written

Doctor's Name (Print):_____ Doctor's Phone:_____

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