Frontier Medical

P.O. Box 1027, Bountiful, UT, 84010
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DME ORDER FORM

Patient's First Name: _____ **Patient's Last Name**: _____

Date of Birth: _____(mm/dd/year) **DOL Case ID:** _____

Height: _____ **Weight**: _____ **Phone**: _____ **Text Preferences** ☐ Yes ☐ No

In order to receive or request any medical items, it is essential that you have been seen by your healthcare provider within the last 6 months. If you have not had an appointment within this time frame, please schedule an appointment with your doctor.

Provider's name: _____

Last Seen by Provider: _____(mm/dd/year)

Scheduled Future Appointment: _____(mm/dd/year)

NUTRITION

All items are subject to review and approval of the Department of Labor. Items must be appropriate for your DOL covered conditions.

SELECT REQUESTED ITEMS(S):

☐ Medical Grade Electrolytes

☐ Nutrition Supplement Drinks

☐ Food Thickener

☐ Beneprotein Powder

☐ Enteral Feeding Pump

☐ Enteral Feeding Bag

☐ Gastro Tube

QTY / SPECIAL REQUESTS:

RESPIRATORY

All items are subject to review and approval of the Department of Labor. Items must be appropriate for your DOL covered conditions.

SELECT REQUESTED ITEMS(S):

☐ Stationary Oxygen Concentrator

☐ Portable Oxygen Concentrator

☐ Portable Oxygen Concentrator Accessories (Backpack, Battery, Power Cords, Etc.)

☐ Oxygen Supplies (Nasal Cannulas, Oxygen Tubing, Etc.)

☐ Filters for Stationary and Portable Oxygen Concentrators

☐ Acapella PEP Device

☐Peak Flow Device

☐ Pulse Oximeter

☐ Incentive Spirometer

☐ PAP Machines with Tubing/Masks

☐ PAP Supplies (Mask, Hose, Water Chamber, Filters, Etc.)

☐ Portable Backup Battery (PAP) w/ 110v Outlet

☐ Portable Nebulizer

☐ Nebulizer Machine with Tubing/Masks

☐ Room Humidifier

☐ Air Purifier

QTY / SPECIAL REQUESTS:

BEDS & EQUIPMENT

All items are subject to review and approval of the Department of Labor. Items must be appropriate for your DOL covered conditions.

SELECT REQUESTED ITEMS(S):

☐ Hospital Bed

☐ Hospital Bed Mattress

☐ Alternating Air Pressure Relief Mattress

☐ Bed Transfer/Positioning Sheet

☐ Bed Overlays

☐ Hospital Bed Rails

QTY / SPECIAL REQUESTS:

☐ Bed Cradle & Foot Support

☐ Transfer Bed Step

☐ Couch/Chair Support Handles

☐ Bed Alarm

☐ Assist-A-Tray

☐ Tilt-Top Overbed Table

☐ Over Bedside Table

☐ Trapeze Bar

AID & MOBILITY

All items are subject to review and approval of the Department of Labor. Items must be appropriate for your DOL covered conditions.

SELECT REQUESTED ITEMS(S):

QTY / SPECIAL REQUESTS:

☐ Transfer Board

☐ Patient Lift

☐ Gait Belt

☐ Lift Chair

☐ Wheelchair

☐ Power Wheelchair

☐ Mobility Scooter

☐ Mobility Ramps

☐ Transport Chair

☐ Rollator Walker

☐ Cane

☐ Crutches

☐Reacher/Grabber Tool

☐ Pedal Exerciser

☐ Exercise Treadmill

☐ Exercise Bike

INCONTINENCE

All items are subject to review and approval of the Department of Labor. Items must be appropriate for your DOL covered conditions.

SELECT REQUESTED ITEMS(S):

- ☐ Ostomy Supplies
- ☐ Catheter Supplies
- ☐ Disposable Absorbent Bed Pads (Chux)
- ☐ Absorbent Underwear Guards / Panty Liners
- ☐ Briefs, Pull-Up or Tab
- ☐ Sani-Cloth Germicidal Wipes
- ☐ Disposable Exam Gloves
- ☐ Personal Care Wipes

QTY / SPECIAL REQUESTS:

BATHROOM AND SUPPLIES

All items are subject to review and approval of the Department of Labor. Items must be appropriate for your DOL covered conditions.

SELECT REQUESTED ITEMS(S):

- ☐ Adjustable Shower Stool
- ☐ Shower Chair
- ☐ Transfer Bench
- ☐ Sliding Transfer Bench
- ☐ Hand-Held Showerhead
- ☐ Grab Bars
- ☐ Safety Rails for Toilet
- ☐ Toilet Seat Riser
- ☐ Commode Chair

QTY / SPECIAL REQUESTS:

BATHROOM AND SUPPLIES

All items are subject to review and approval of the Department of Labor. Items must be appropriate for your DOL covered conditions.

SELECT REQUESTED ITEMS(S):

- ☐ Back Brace
- ☐ Knee Brace
- ☐ Compression Sleeves

QTY / SPECIAL REQUESTS:

☐ Compression Socks

☐ Diabetic Socks

☐ Diabetic Sleeves

☐ Pneumatic Leg Compression

☐ Truss or Hernia Belt

☐ Abdominal Binder

☐ Tracheostomy Care

☐ AED Device

☐ Inhaler Spacer

☐ Paraffin Bath (hand/foot wax unit)

☐ Tens Unit & Accessories

☐ Wedge Pillow / Positioning Cushion

☐ Weight Scale

☐ Blood Pressure Monitor

☐ Thermometer

☐ Suction Machine & Supplies

☐ General Wound Care

Patient Signature: _____ **Date** : _____

Authorized Representative Name (if applicable): _____ **Relationship**:_____

Authorized Representative Signature: _____ **Date**:_____

I acknowledge that receiving these items is not guaranteed and are subject to approval from the Department of Labor. By submitting this form, it will trigger a call from Frontier Medical to review and discuss selected items, notes, special requests and my personal information.