JOHNS HOPKINS PHARMAQUIP
Home Medical Equipment
Dispensing Order

JOHNS HOPKINS MEDICINE
Care at Home

5901 Holabird Ave., Suite A
Baltimore, MD 21224
Phone: 410-288-8150
Fax: 410-282-8455

ACCT#

Patient Name: (Last, First)	Address: (include zip code)	Contact Phone:
Primary Insurance: **Policy Number #**	**Secondary Insurance:** Policy Number:	Date of Birth: Height_____Weight_____
Diagnosis:	Length of Need -	

Check the appropriate boxes to prescribe equipment and/or supplies. * If deleting any supply, indicate and initial

Oxygen System and Supplies*

Prescription:

Setting: _____lpm or _____%

Duration: ☐ Continuous ☐ Other_____

Device: ☐ NC ☐ Trach Collar ☐ Other:_____

Initiate Conserving Device for portable use

Standard Setting 1-5 Keep SaO2 above_____%

Qualifications: Location of Test:_____Date of Test__/__/__

☐ **TEST TAKEN AT REST**:

Saturation: _____% or PaO2_____on ☐ Room Air or ☐ ____lpm

☐ **TEST TAKEN DURING EXERCISE/AMBULATION**:
(All below must be completed within same time frame)

SaO2 at rest without O2_____%

SaO2 during exercise without O2_____%

Sao2 during exercise with O2_____%

Supplies:** delivery device, Tubing, portable tanks, regulators

☐ Wheelchair

Prescription: ☐ Standard ☐ Lightweight ☐ Heavy Duty

Supplies/Accessories: ☐ Elevating Legrests ☐ seatbelt ☐ armrest ☐ anti-tippers

☐ Hospital Bed

Prescription: ☐ Semi-Electric **OR** ☐ Full-Electric *

Supplies/Accessories: ☐ Full Rails **OR** ☐ Half Rails

☐ Trapeze Bar: ☐ Fixed **OR** ☐ Floor stand

☐ Hoyer Lift w/ standard sling

☐ Ambulatory Aids

Prescription: (only one below can be provided)

☐ Cane: ☐ Straight **OR** ☐ Quad

☐ Crutches: ☐ Standard **OR** ☐ Forearm

☐ Walker: ☐ Adult **OR** ☐ Youth **OR** ☐ with seat

☐ Walker Wheels: ☐ 5" **OR** ☐ 3"

☐ Bath Aids

Prescription:

☐ Commode: ☐ Standard **OR** ☐ Drop Arm

☐ Shower Chair: ☐ Standard **OR** ☐ With Back

☐ Transfer bench

☐ Suction Machine and Supplies*

Prescription: ☐ Oral **OR** ☐ Tracheal/Oral

☐ Suction Catheters
Size: _____Fr Quantity: _____/Month

** if ordered for >300 per month, medical justification needed

***Supplies/Accessories:** Jar, Tubing, Yankauer

☐ Nebulizer and Supplies

Prescription: ☐ Stationary **OR** ☐ Portable**

Supplies: Nebulizer kits, Masks

**may not be covered

Physician Name:	Address:	PHONE # Fax #
Physician Signature:	**NPI #:**	**Date:**

This form must be signed and dated by the prescribing physician before the therapy/equipment may be considered for payment. Physician's signature certified that the above represents his judgment of the patient's need for the therapy/equipment.