DIAMOND

Questions? (800) 977-3002
STANDARD WRITTEN ORDER

Order Date

Height Weight

Doctor's Name

NPI #

Patient's Name

LA FIRE REPLACEMENT
FAX THIS FORM TO:
(800) 438-2048

CONTINUOUS GLUCOSE MONITOR (CGM)

FreeStyle dexcom

☐ **CGM Reader** (E2103)

☐ **Sensor for CGM** (A4239)

Length of need: _____

Refills: _____

WALKER/COMMODE:

If your patient requires a different type, please contact us at: (800) 977-3002

☐ **Walker w/wheels** (E0143) ☐ **HD Walker** (E0149)

Walker accessories:

☐ **Seat attachment** (E0156)

☐ **Platform Attachment** (E0154) ☐ **Leg extension** (E0158)

Commode

☐ **Bedside Commode**

BRACES/TENS:

Neck

☐ **Vista MP Neck Brace** (L0180)

TENS

☐ **TENS device** w/4 leads

Shoulder

☐ **Shoulder Elbow Wrist Hand Orthosis** (L3960)

Back

☐ **Aspen Vista 464 TLSO** (L0464)

☐ **Aspen OTS 650 LSO** (L0650)

☐ **Aspen Vista 648 TLSO** (L0648)

☐ Other: _____

Wrist

☐ **Wrist Hand Finger Orthosis (WHFO), without joints**

☐ Left ☐ Right ☐ Bilateral (x2)

Knee

☐ **CK-111 Hinged Knee Support Brace** (L1833)

☐ Left ☐ Right ☐ Bilateral (x2)

WHEELCHAIR:

1. Choose a wheelchair base:

☐ **Standard Wheelchair**

☐ **Hemi-height (Low Seat) Wheelchair**

☐ **Transport Wheelchair**

☐ **Heavy Duty Wheelchair**

2. Add accessories (optional)**:**

☐ **Standard foot rests** ☐ **Seat cushion**

☐ **Elevating leg rests** ☐ **Anti-tip back device** (x2)

☐ **Back cushion** ☐ **Wheel lock extension** (x2)

BARTON CHAIR/BEDS (Patient Transfer System)

☐ Multi-positional patient transfer system with integrated seat **<300** pounds (E1035)

☐ **Heavy Duty** Multi-positional patient transfer system with integrated seat **>300** pounds (E1036)

Hospital Bed

☐ Hospital bed, fixed height, with any type side rails, with mattress (E0250)

☐ Hospital bed, **heavy duty**, extra wide, weight capacity >300# and <600# with rails and mattress (E0303)

I Certify that a face to face evaluation was performed within 6 months of the date of this prescription.

For Office Use

Dr. Signature

Date of Signature

DIAMOND

Questions? (800) 977-3002

DETAILED WRITTEN ORDER - RESPIRATORY

Order Date

Doctor's Name

NPI #

Patient's Name

LA FIRE REPLACEMENT
FAX THIS FORM TO:
(800) 438-2048

OXYGEN:

Please send pulse oximetry or ABG results with this form. Qualifying results are Po2 <=55 (ABG) -OR- pulse ox of 88% or below.

☐ **Stationary Oxygen Concentrator** (E1390)

☐ **Portable Gaseous Tank** (E0431)

☐ **Conserving Device**

@ _____ Liter Flow (LPM)

To be used:

☐ **Continuously**

☐ **While ambulating** _____ Hours per day

☐ **Nocturnally**

Via

☐ **Nasal Cannula** ☐ **Mask**

☐ **Trachea Collar** ☐ **Bleed into PAP therapy**

Other Orders

CPAP / BiLEVEL / BiLEVEL ST:

Please send baseline sleep study, titration and office notes (dated prior to **baseline** sleep study) with this form.

☐ **CPAP** (E0601) ☐ **Auto CPAP** (E0601)

Pressure or range: _____ cm H2O

BiLevel (Also known as BiPAP or RAD)

☐ **RAD w/o back up rate** (E0470) I/E _____ cm H2O

☐ **RAD with back up rate** (E0471) I/E _____ cm H2O + B/U Rate

☐ **Heated Humidifier** (E0562)

Accessories: Replace according to the following schedule

☐ **Full Face Mask** (A7030) 1/3mo ☐ **Nasal Mask** (A7034) 1/3mo
☐ **Face Mask Cushion** (A7031) 1/mo ☐ **Nasal Cushions** (A7032) 2/mo
☐ **Disposable Filters** (A7038) 2/mo ☐ **Nasal Pillows** (A7033) 2/mo
☐ **Heated Tubing** (A4604) 1/3mo ☐ **Std Tubing** (A7037) 1/3mo
☐ **Headgear** (A7035) 1/6mo

** Unless brand and size are specified the best fitting mask will be provided to patient.

Specific Instructions

NON-INVASIVE VENTILATION

Please complete the following **only** for patients with Chronic Respiratory Failure secondary to COPD, restrictive thoracic disorder, Obesity Hypoventilation Syndrome or neuromuscular disorders.

☐ **Trilogy Evo** (E0465 or E0466) ☐ **Astral** (E0465 or E0466)

☐ **AVAPS AE or IVAPS 6-8ml/kg Vt via mask continuous**

☐ **PS w/Vt - PS 5, PEEP 5, RR 10, Vt500 continuous** (Astral Only)

☐ **Daytime mode: Mouth piece ventilation with AC or PAC(V) 800cc x, Ti 1.5 (adjust to comfort), square wave**

Other settings: _____

NEBULIZER:

☐ **Nebulizer Machine** (E0570)

☐ **Non disposable neb circuit** (A7005) **Refill 1/6 mo.**

☐ **Disposable neb circuit** (A7003) **Refill 2 per mo.**

☐ **Aerosol mask** (A7003) **Refill 1/6 mo.**

Medication (name, concentration, dose, frequency):

I Certify that a face to face evaluation was performed within 6 months of the date of this prescription.

Dr. Signature

Date of Signature

For Office Use