Phone: 248-299-3330
Fax: 248-299-3332
intake@thehomedme.com

DETAILED WRITTEN ORDER PRIOR TO DELIVERY (DWOPD)

Name: _____ D.O.B._____ Order Date: _____

Start Date (if the start date is different from the date of the order) _____

Height_____ Weight_____ Address_____

_____

Primary Diagnosis:_____ Secondary DX:_____ Duration of Need: _____1-99

Wheelchair and Accessories

☐Standard Manual Wheelchair K0001 ☐Wheel Lock Extensions E0961 ☐Anti-Tippers E0971

☐Foam Back Cushion E2611 (20" or less) ☐Foam back Cushion E2612 (22" or greater) ☐Foam Seat Cushion E2601 (20" or less)

☐Foam Seat Cushion E2602 (22" or greater) ☐Air Cell Cushion E2622 ☐Pressure Reducing Cushion E2603

☐Heavy Duty Manual Wheelchair K0006/K0007 ☐Elevating Leg Rest E0990

Hospital Bed and Accessories

☐Semi-Electric Hospital Bed E0260 ☐Bariatric Bed E0303 (Weight requirement 350 or greater) ☐Fixed Height Hospital Bed E0250

☐Trapeze attached to the bed E0910 (Up to 250lbs) ☐HD trapeze attached to the bed E0911 (251lbs or greater)

☐Free standing trapeze E0940

Commode

☐Commode E0163 Is the patient room or floor confined or unable to access toilet facilities **Y**_____ **N**_____ (If no, not covered)

☐ Bariatric Commode E0168 (Weight requirement 300 or greater)

☐Drop Arm Commode E0165 It necessary to facilitate transferring of the beneficiary or has body configurations that require extra width and patient is room or floor confined and unable to access toilet facilities. **Y**_____

Physicians Name_____ NPI_____

Physician Signature_____ Date_____