

**REMINDER: ALL MEDICATION ORDERS REQUIRE DOSE, ROUTE, FREQUENCY AND INDICATION
DO NOT USE ABBREVIATIONS**

DOCTORS ORDERS DURABLE MEDICAL EQUIPMENT ORDERS	CHECK OFF/ INITIALS
Please Obtain for Home Use:	
<input type="checkbox"/> Wheeled Walker <input type="checkbox"/> 3 inch wheels <input type="checkbox"/> 5 inch wheels	
<input type="checkbox"/> Standard Walker <input type="checkbox"/> Platform Walker	
<input type="checkbox"/> Wheelchair <input type="checkbox"/> ↑ Leg Rest Reason: _____	
<input type="checkbox"/> Quad Cane <input type="checkbox"/> Wide Base Quad Cane <input type="checkbox"/> Regular Adjustable Cane	
<input type="checkbox"/> 3-in-1 Bedside Commode	
<input type="checkbox"/> Hospital Bed	
<input type="checkbox"/> Air Mattress	
<input type="checkbox"/> Oxygen <input type="checkbox"/> Concentrator <input type="checkbox"/> Liquid <input type="checkbox"/> Portable Tank <input type="checkbox"/> Continuous at _____ L/min at Rest at _____ L/min at Activity at _____ L/min at Night/Sleep	
<input type="checkbox"/> Continuous Positive Air Pressure Settings: _____	
<input type="checkbox"/> BiPAP Settings: _____	
<input type="checkbox"/> Apnea Monitor _____ Bradycardia _____ Tachycardia _____ Apnea Delay	
<input type="checkbox"/> Accucheck Advantage Frequency of Testing: _____	
<input type="checkbox"/> Insulin Dependent Diabetes Mellitus	
<input type="checkbox"/> Non-Insulin Dependent Diabetes Mellitus	
<input type="checkbox"/> Continuous Passive Motion Settings: _____ Extension: _____ Flexion: _____	
Special Instructions:	
Other:	
Diagnosis:	
Height: _____ Weight: _____	
Physician/Date/Time: _____	Nurse/Date/Time: _____
Secretary/Date/Time: _____	

Full page of orders requires only one physician, one nurse and one clerical signature



Original to Patient's Chart

Fax to Pharmacy