Detailed Written Order

Alliance MEDICAL SERVICES
MEDICAL EQUIPMENT

3440 College Street
Beaumont, TX 77701
(409) 347-0173
Fax (409) 347-0283
amsdmetx.com

Patient Information

Name: _____ Phone #:_____ DOB:_____

Pt Address: _____ City: _____ State:_____ Zip:_____ HT:_____ WT:_____

Primary Insurance: _____ Policy #:_____

Secondary Insurance: _____ Policy #:_____

Diagnosis: _____ **Length of Need:**_____ months (99=lifetime)

Sleep Therapy

____Auto CPAP Pressure: _____ cmH2O (4-20 cmH2O)

____CPAP Pressure: _____ cmH2O

____BIPAP Pressure: _____cmH2O / EPAP: _____ cmH2O

____CPAP/BIPAP Supplies ____Heated Humidifier

O2/Respiratory Therapy (This information is needed only if you are ordering oxygen.)

____Nebulizer ____Nebulizer Kit

____Oxygen Concentrator LPM:_____ Freq:_____ Via:_____

____Portable Oxygen

O2 SAT: _____ Test Date:_____

Durable Medical Equipment

____Semi-Electric Hospital Bed	____Wheelchair	____Rolling Walker
____Patient Lift	____LT Wheelchair	____ Rollator (seat & brakes)
____Trapeze Bar	____ Power Wheelchair	____Roll-A-Bout
____Gel Overlay	____ Wheelchair Gel Cushion	____CPM
____Alternating Pressure Pad	____ Elevating Leg Rest	____Brace Type_____ Lt__Rt__
____Low Air Loss Mattress	____SLEEQ Back Brace	____TENS Unit

Other:_____

Physician/Practitioner Signature: _____ **Date:**_____

Printed Name: _____ **NPI:**_____

Phone:_____ **Fax:**_____