



STANDARD WRITTEN ORDER / CMN
1804 Owen Drive, Fayetteville, NC 28304
1-910-864-3810 (Phone) · 1-910-864-4371 (Fax)

* Date of Order _____

* Patient Name _____ DOB _____

Primary Diagnosis _____

Secondary Diagnosis _____

Length of Need _____ (99 = Lifetime) HT _____ WT _____

RESPIRATORY EQUIPMENT

Oxygen Concentrator: ___LPM Portable Gaseous System and content(s)? ___Y ___N

[] Conserving Device [] Home Fill Compressor

[] Continuous via Nasal Cannula or Other _____ OR [] Nocturnal via Nasal Cannula or Other _____

[] Nebulizer [] Nebulizer Filter 2/month [] Nebulizer Set 2/month

HOME MEDICAL EQUIPMENT

- [] Seat Lift Chair/Mechanism [] Straight Cane [] Quad Cane [] Walker
[] Rolling Walker [] Rollator [] Transport Chair [] Non-Standard Seat Frame Wheelchair
[] Manual Wheelchair [] Motorized Wheelchair [] Amputee Limb Support [] Wheelchair Seat Cushion
[] Wheelchair Back Cushion [] Elevating Legrest [] Anti-tippers [] Shower Chair
[] Transfer Bench [] Hospital Bed [] Trapeze Bar [] Patient Lift Hydraulic
[] Commode [] Other _____

Decubitus Care Items: [] Dry Pressure Mattress [] Gel Overlay Pad for Mattress
[] Alternating Pressure Pad & Pump [] Powered Pressure-Reducing Air Mattress (Low Air Loss)

* Print Name or NPI _____

* Physician/Treating Practitioner Signature _____

* Medicare Required Fields