M&M Medical Supplies

180 S SPRUCE AVE #D
S SAN FRANCISCO, CA 94080
(650) 758-1320

The Joint Commission

PLEASE FAX TO (650)758-1390

• MEDICARE & CARE ADVANTAGE • MEDI-CAL- HEALTH PLAN OF SAN MATEO • CHINEASE COMMUNITY HEALTH PLAN • NORTH EAST MEDICAL SERVICES • ALL AMERICAN MEDICAL GROUP • SAN FRANCISCO HEALTH PLAN	• IMPERIAL HEALTH • ACE • MCE • HEALTHWORX • BRAND NEW DAY

PATIENT INFORMATION	INSURANCE INFORMATION
Full name: Address: Telephone #: Contact person: Date of Birth: Height: Weight:	Insurance: Policy #: Effective date: Other insurance:

PHYSICIAN INFORMATION

Primary care physician:

Telephone #:

Fax #:

Diagnosis:

Physician Signature: Date:

PATIENT ROOM	SEATING/POSITIONING
☐ Hospital bed, mattress, rail ☐ Trapeze bar ☐ Patient LIft ☐ Others:	☐ Gel overlay ☐ Alternative pressure pad w/ pump ☐ Alternative pressure mattress ☐ Standard Cushion for wheelchair ☐ Gel cushion for wheelchair

MOBILITY

☐ Cane	☐ Quad cane
☐ Walker	☐ Crutches
☐ Walker w/ seat	☐ Hemi-walker
☐ Transport chair	

Wheelchair ☐ Lightweight ☐ Standard ☐ Reclining

ORTHOTICS (Please Specify)

- ☐ Back
- ☐ Hand
- ☐ Wrist
- ☐ Knee
- ☐ Ankle
- ☐ Foot
- ☐ Other

BATHROOM SAFETY

- ☐ Commode (3 in 1)
- ☐ Shower chair
- ☐ Transfer bench
- ☐ Bath stool
- ☐ Raised toilet seat
- ☐ Others:

DIABETIC

- ☐ Diabetic shoes
- ☐ Continuous blood glucose monitors
- ☐ Blood glucose monitors
- ☐ Compression stockings

Style (circle one): Knee Thigh

Size (circle one): Small Medium Large X-Large

INCONTINENCE

- ☐ Diapers

Quantity(pcs/month):

Size: ☐ Small ☐ Medium ☐ Large ☐ X-large

- ☐ Pull-ups

Quantity(pcs/month):

Size: ☐ Small ☐ Medium ☐ Large ☐ X-large

- ☐ Underpads

Quantity(pcs/month):

- ☐ Liners (Pantry)

Quantity(pcs/month):

- ☐ Underwear (reusable)

Quantity(pcs/month): *LIMIT OF 2 EVERY MONTH

- ☐ Waterproof sheeting (reusable): *LIMIT OF 1 EVERY 6 MONTHS
- ☐ Wash Quantity(pcs/month):
- ☐ Wipes Quantity(pcs/month): *LIMIT OF 10 PACKS EVERY MONTH
- ☐ Gloves Quantity(pcs/month): *LIMIT OF 2 BOXES EVERY MONTH
- ☐ Cream Quantity(pcs/month):

PLEASE FAX TO (650)758-1390

M&M Medical Supplies

180 S Spruce Ave Unit D
South San Francisco, CA 94080
Bus. 650-758-1320
Fax. 650-758-1390
Email. Service@DMEbayarea.com

Sleep Therapy/Oxygen Therapy Order Form

REFERRAL SOURCE

Office name _____ Office contact name _____

Date _____ Phone _____ Fax _____

PLEASE SEND PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION

PATIENT INFORMATION

Patient name _____ DOB _____
Last First

Home phone _____ Mobile phone _____

Diagnosis ICD-9

- ☐ 327.23 Obstructive Sleep Apnea (Adult and Child)
- ☐ 327.21 Primary Central Sleep Apnea (Includes Complex Sleep Apnea)
- ☐ 786.04 Cheyne-Stokes Breathing Pattern
- ☐ Other _____

SLEEP THERAPY

PLEASE SEND SIGNED AND DATED COPY OF FACE-TO-FACE DISCUSSION DOCUMENTING SIGNS AND SYMPTOMS OF OSA, DIAGNOSTIC SLEEP STUDY AND TITRATION STUDY (IF APPLIABLE) FROM PATIENT'S CHART

Estimated length of need _____ months (99 = lifetime)

Date of the scheduled re-evaluation appointment with prescribing physician (no sooner than the 31st day and no later than the 91st day after setup): _____

- ☐ Face-to-face evaluation/physician chart notes (for Medicare patients) Date _____
- ☐ Completed sleep study Date _____ AHI/RDI _____
- ☐ Secondary diagnosis (if AHI/RDI is 5 – 14) _____
- ☐ **CPAP** _____ cm H_2O (4 – 20 cm H_2O) Ramp time _____ min(s) (OFF – 45 min)
- ☐ **Bi-level** Pressure: IPAP _____ cm H_2O EPAP _____ cm H_2O (4 – 25 cm)
- ☐ **Auto Adjusting Bi-level** Max IPAP _____ cm H_2O _____ Min EPAP _____ cm H_2O (4 – 25 cm)*
  Ps min _____ cm H_2O (0 – 8 cm) Ps max _____ cm H_2O (Ps min -8 cm) *EPAP must be lower than IPAP
- ☐ Heated humidification
- ☐ Patient to choose mask to comfort, OR ☐ Mask type _____ Mask size ☐ S ☐ M ☐ L

By my signature below, I authorize the use of this document as a dispensing prescription. I understand that the final decision with respect to ordering this (these) item(s) for this patient is a clinical decision made by me, based on the patient's clinical needs, and that my medical records support the medical need for the items prescribed.

Print prescriber's name _____ **NPI #** _____

Prescriber signature _____ **Date** _____