Hospice Order Form

Detailed Written Order

Patient Name: _____ **Discharge Date**: _____
(*Equipment delivered by*)

Weight: _____ lbs. **Height** _____ in. **Dx Code**: _____

Mobility Equipment

☐Cane- Single Point ☐Quad Cane Small/Large Base ☐Walker w/ Wheels ☐Walker w/o Wheels
☐Heavy Duty ☐Rollator ☐Junior Walker

Other: _____

Wheelchair

Recommended Seat Size: _____ width
Wheelchair Type: ☐Transport Chair ☐Hemi Height ☐Lightweight ☐High Back ☐Bariatric ☐Geri Chair w/ Tray
Wheelchair Accessories: ☐Elevating Leg Rest ☐Anti-Tippers ☐Standard Cushion ☐Gel Cushion
☐Specialty Cushion (ROHO, Pommel or Star) ☐Transfer Board ☐Wheelchair Alarm

Other: _____

Hospital Bed

Bed Type: ☐Full Electric w/ Group 1 Mattress ☐ Bed Low Full Electric w/ Group 1 Mattress ☐Bariatric
Rail Type: ☐Full Rails ☐Half Rails
Mattress Type: ☐Gel Overlay (*Group 1*) ☐Therapeutic (*Group 1*) ☐Low Air Loss Mattress (*Group 2*)
Accessories: ☐Hoyer Lift w/ sling ☐Trapeze Bar Bariatric ☐Trapeze Bar ☐Bed Alarm
☐Bed Extension Kit ☐Bed Wedge ☐Fall Pad ☐Wheelchair Alarm

Other: _____

Respiratory

☐Nebulizer w/ kits ☐Suction Machine Table Top ☐Gomco Suction Machine w/ Set Up
☐Concentrator 5L w/ Setup ☐ Concentrator 10L w/ Setup ☐50 PSI Compressor Set up
☐CPAP Settings: _____ ☐ BiPAP Settings: _____ ☐Ventilator Settings: _____

Other: _____

Bathroom Equipment & Miscellaneous:

☐Bedside Commode ☐Drop Arm Commode ☐Heavy Duty
☐Shower Chair w/o back ☐Shower Chair w/ back ☐Tub Transfer Bench
☐Feeding Pump w/ Accessories

☐ Pull Ups: Size: _____ QTY: _____ Refills: **Y/ N** ☐ Diapers: Size: Size: _____ QTY: _____ Refills: **Y/ N**
☐Under-pads QTY: _____ Refills: **Y/ N** ☐Wipes QTY: _____ Refills: **Y/ N**

Other: _____

Authorized Signature: _____ Date: _____

Axis Medical Equipment & Supply, LLC
3214 E Belt Line Rd. Ste 426 Farmers Branch, Tx 75234
P: 972-889-2947 F: 972-767-4762