

Office (818) 713-0202



Fax (818) 713-0879

Apguard Medical, Inc.
DME PRESCRIPTION

Original Rx Updated Rx Discontinue Rx

Patient Information

Patient's Name _____ DOB ____/____/____ Order Date ____/____/____

Address _____ City _____ Zip _____ Phone _____

Dx(ICD 9): COPD(496) CHF (4280) CVA (436) Osteoarthritis, General Other: _____

Equipment Length Of Need: 12 mos. 99 mos. Other: _____

Insurance Information

Medicare # _____ Medi-Cal # _____

Insurance Company _____ ID# _____ Phone Number _____

Medical Equipment

All Orders Must Include: Height _____ Weight _____

Bedside Commode: 3 in 1 (Std) Extra Wide Drop Arm Mobile

Raised Toilet Seat: w/Arms Shower Chair (w/Back) Shower Bench (w/o Back)

Front Wheeled Walker Pick-up Walker (no wheels) Heavy Duty Hemi 4 Wheel w/Brakes/Seat/Basket

Accessories: Brakes 5" Wheels Glide Tips Seat Basket

Wheelchair: Standard Narrow Hemi Light Weight Ultra Light Weight Companion/Transport

Recliner Heavy Duty Extra Heavy Duty Geri/Cardiac Chair

Accessories: Elevating Leg Rests Footrests Removable Arm Rests Desk Arms

Wheelchair Cushion: Type: _____

Crutches: Std Heavy Duty Forearm Canes: SPC Quad-Narrow Quad-Wide Heavy Duty

Hospital Bed: Full Electric Semi Electric Heavy Duty Trapeze: Std Free Standing Fracture Frame

Low Air Loss Mattress Alternating Pressure Pad and Pump Patient Lift and Sling: Std Commode Opening

Enteral: _____ cc's & Freq: _____ Pump Gravity Bolus Food Type: _____

OTHER: _____

Physician Information:

Physician Signature _____

Date ____/____/____