DEPENDABLE OXYGEN & MEDICAL EQUIPMENT

DOME
INTERNATIONAL, INC

DURABLE MEDICAL EQUIPMENT STATEMENT OF ORDERING PHYSICIAN

Please send completed form along with patient's face sheet & applicable clinical notes

PHONE: (718) 854-5501 • FAX: (718) 369-5858

Patient Name:	**Date of Birth:**_____/_____/_____ ☐M ☐F
Address: _____ _____	**Insurance ID:**
	Diagnosis:_____,_____,_____,_____, _____

RENTAL ITEMS

HCPCS	ITEM DESCRIPTION	QTY
E0465	VENTILATOR WITH OR W/O PRESSURE SPRT	1
E0570	NEBULIZER AEROSOL COMPRESSOR	1
E0600	SUCTION MACHINE	1
E0565	HEAVY DUTY COMPRESSOR	1

PURCHASE/RENTAL ITEMS

HCPCS	ITEM DESCRIPTION	QTY
E0445	CONTINUOUS PULSE OXIMETER FREQUENCY: CONTINUOUS USE	1

SETTING:

Ventilator usage:_____hours/day
A ventilator Respirator Rate of _____
In_____mode,
A tidal Volume of_____ml,
PEEP of_____cm. H20
A Sigh Volume of_____ml (if applicable)
Oxygen at_____LPM @_____% if (applicable)

SUPPLIES

HCPCS	ITEM DESCRIPTION	QTY
A7004	NEB CUP	2
A7013	FILTER, DISPOSABLE	2
A7003	NEB KIT	2
A7000	SUCTION CANISTER DISP	10
A7002	SUCTION TUBING DISP	10
A4605	SUCTION CATHETER CLOSED SYSTEM	30
A4624	SUCTION CATHETER KITS_____FR OPEN	250
A4628	SUCTION YANKAUER	30
A4629	TRACH CARE KIT/ESTABLISHED TRACH	30
A4623	TRACH DISPOSABLE INNER CANNULA SIZE _____	60
A7525	TRACH MASK	1
A7526	TRACH TIES	30
A7521	TRACH TUBE CUFFED SIZE_____	1
A7520	TRACH TUBE UNCUFFED SIZE_____	1
A4217	STERILE WATER/SALINE 500mL BTL	72
A4216	STERILE WATER/SALINE 10 mL	144
A7007	JET NEB BTL	10
A7010	CORRUGATED TUBING	1
A4483	TRACH HEAT/MOISTURE EXCHANGE SYSTEM	30
A4649	GAUZE 4X4 SPLIT DRESSING (50/bx)	2
A6402	STERILE GAUZE, NON-IMPREGENATED, EACH (50/bx)	2

THE ABOVE IS MEDICALLY NECESSARY BECAUSE:

PATIENT REQUIRES MECHANICAL VENTILATOR SUPPORT DUE TO HYPOXEMIC RESPIRATORY FAILURE.
PATIENT REQUIRES CONTINUOUS HUMIDIFICATION TO LOOSEN THICK AND TENACIOUS SECRETIONS.
PATIENT HAS A MEDICAL CONDITION CAUSING DIFFICULTY RAISING AND CLEARING SECRETIONS.
PATIENT HAS A MEDICAL CONDITION WHICH REQUIRES THE ADMINISTRATION OF INHALATION THERAPY.
INHALATION SOLUTION/DOSAGE/FREQUENCY_____*
USE OF AN MDI HAS BEEN CONSIDERED, BUT RULED OUT.
PATIENT HAS AN OPEN SURGICAL TRACHEOSTOMY AND IS EXPECTED TO REMAIN OPEN FOR AT LEAST 3 MONTHS

Start Date:_____/_____/_____ **Length of Need (# of months)_____1-99 (99 = Lifetime)**

Prescriber Name:	**Address:** _____ _____	**Phone #:** **Fax #:**
Prescriber Signature **X**_____	**Date:** _____/_____/_____	**Prescriber NPI #:** **PECOS REGISTERED? ☐ Y / ☐ N**

***NOTE TO PHYSICIAN: THIS FORM WAS FILLED OUT ACCORDING TO INFORMATION WE RECEIVED FROM YOUR OFFICE AND/OR YOUR PATIENT. BY SIGNING THIS FORM YOU ARE CERTIFYING THAT YOU HAVE REVIEWED IT FOR ACCURACY AND THERE IS SUPPORTING DOCUMENTATION VERIFYING THIS INFORMATION IN THE PATIENTS PERMANENT MEDICAL RECORDS AND THAT INFORMATION IS AVAILABLE UPON REQUEST.**