Home Medical Equipment and Oxygen
450 State Route 664 North • P.O. Box 997 • Logan, Ohio 43138
Phone: (740) 385-6177 or 1-800-423-3615 •FAX: (740) 385-0474
242 W. 6th Ave. • Lancaster, Ohio 43130
Phone: (740) 652-9250 or 1-800-423-3625 •FAX: (740) 652-9253

Physician Order:
SUCTION MACHINE
SUCTION SUPPLIES

Below is confirmation of your order, and a completed order, for a Suction Machine and/or Suction Supplies for:

Patient Name________________________ **HIC#**_______________________

Address_____________________________**City**_________________**State**___**ZIP**__________

Date of Birth__________**Height**________**Weight**________

Diagnosis (including ICD-9 codes)____

Equipment Ordered____

Supplies Ordered____
____

Patient Medical Need:
1. Does the Patient have difficulty raising or clearing secretions? Yes No
2. Does the Patient have cancer or surgery of the throat or mouth? Yes No
3. Does the Patient have dysfunction of the swallowing muscles? Yes No
4. Is the Patient unconscious or in an obtunded state? Yes No
5. Does the Patient have a tracheostomy? Yes No

Initial Order Renewal Order; Order Date:________________
Date patient last Examined:_________________________________
Length of Need: Lifetime Other _______________________________________

This order is being processed following receipt of referral from You Your staff
Hospital: ____
My signature below signifies that the items listed above have been ordered by me for the beneficiary noted above, and the information contained herein is true and correct and accurately reflects the patient's medical condition and the treatment regimen I have prescribed. I also affirm that my medical records for this patient contain sufficient clinical information to justify the items ordered.

Physician Signature____**Date:**__________

Physician Name:____ **NPI:** ________________

Address:____