NORTHEAST MEDICAL PRODUCTS, INC
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COMMODE ORDER FORM

Patient_____ TEL: _____

Address_____

DOB _____

Diagnosis codes _____

Length of Need: _____ Height _____ Weight _____

Equipment:

_____ E0163 Commode

_____ E0165 Drop Arm Commode

_____ E0168 Bariatric Commode

Coverage questions:

Y	N	Is there a bathroom in the home?
Y	N	Is the patient confined to one level of the home that has no bathroom?
Y	N	Is the patient confined to one room in the home?
Y	N	Does the patient require drop arms to facilitate transfer to commode?
Y	N	Does the patient weigh more than 300 lbs?

Physician Name_____ Phone _____

Address _____

Fax _____ NPI _____

_____

Signature Date