COMMODE-ORDER FORM/RX

DATE OF ORDER: **Length of Need:_____**

PATIENT NAME: DOB:
ADDRESS: HT:_____ WT:_____
CITY:
PHONE:
PT ID:

ICD 10 Code1_______________ ICD 10 Code3_______________
ICD 10 Code2_______________ ICD 10 Code4_______________

MEDICAL EQUIPMENT ORDER:

____Commode Standard Bedside: E0163

____Commode Drop Arm: E0165

____Commode Bariatric: E0168

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 to facilitate transfer to commode?
Y **N** Does the patient weigh more than 300 lbs?

Doctors Name: NPI:

Address:

Fax # Phone #

Doctors Signature ________________________________ Date__________