13000 HARBOR CENTER DR. SUITE 312 WOODBRIDGE, VA 22192
TEL: (804) 729-9055 FAX: (888) 752-5586

Physician Consent Form for DME/Mobility Equipment Supplies

Physician: Your patient is requesting for supplies of the equipment specified below. Please authorize ARM Medical Equipment to dispense these items by completing the following consent/authorization form.

Patient Information:				
Name:	DOB:	Name of Facility:		
Address:			City/State:	Zip:
Phone:				

Insurance Information:	
Primary:	Secondary:
ID#:	ID#

Clinical Information		
Diagnosis:	Equipment Ordered:	
Surgery:	Date:	
Equipment Settings:		
Limits:	Adv. Settings	Length of time needed
Height:	Weight:	
Specific Instructions:(e.g., Remove brace while on CPM)		

Equipment Setup:
Wheelchair: ❑Elevated leg rest ❑Standard leg rest ❑Reclining back ❑Seat cushions ❑Seatbelts Wheelchair size based on patient's BMI:
Hospital Bed: ❑Full Electric ❑Semi-Electric ❑Side Rails (Prescription only) ❑Spring Mattress ❑Foam Mattress
❑Rollator ❑Walker (with/without wheels) ❑Shower Bench ❑Commode ❑
Other Equipment (provide adequate description below or attach physician's order)

Physician Information:		
Name:	Phone:	
Address:	City/State	Zip: