Orbit Medical
Phone: (800) 430-0539
Fax: (800) 430-0255

DME REQUEST FORM

Please complete this form with every order to ensure Orbit has everything necessary to process the request in a timely manner.

Account Information

Account: _____

Account Contact: _____ Phone: _____ Fax: _____

Sales Rep: _____ Cell: _____

Equipment Request:_____

☐ Manual Wheelchair	☐ Oxygen ____LPM	☐ Hospital Bed	☐ Low Air Loss Mattress
☐ Power Wheelchair	☐ Back Brace	☐ Walker	☐ Commode
☐ Hoyer Lift	☐ Knee Brace	☐ Rollator	☐ Other _____

Patient Information

Patient Name*: _____ **Height***:_____ **Weight***:_____
Delivery Info
Contact for delivery: _____ Phone: _____

Delivery Address: _____

Prescribing Physician: _____ Fax Rx to: _____

The following is attached:

- ☐ **Patient's demographic sheet***
- ☐ **Chart Notes* (within the past 120 days, signed by the MD)**
- ☐ **History and Physical**

***Required fields**

Discharge Information

Is the patient discharging? YES NO

Discharge Date: _____ Discharge Facility: _____