

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: _____

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