



Prescription Durable Medical Equipment

Phone: 661 393 4877 Fax: 661 393 7339 Email: intake2@kernmedicalsupply.com

Name: _____ Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Insurance Company: _____ Policy #: _____
 Date of Birth: _____ Height _____ Weight _____ Diagnosis _____

Physician Name: _____
 Phone #: _____
 Fax #: _____
 NPI #: _____

Please select how long your patient needs to use the items requested.

LENGTH OF NEED _____ MONTHS LIFETIME**

Wheelchairs

- Standard<300** (K0001), Flip Arms(E0973), Large Seat(E2201), Anti Tippers(E0971), Foam Cushion(E2601), Back Cushion(E2611)
- Lightweight<300** (K0003), Flip Arms(E0973), Large Seat(E2201), Anti Tippers(E0971), Foam Cushion(E2601), Back Cushion(E2611)
- Ultra Light<300** (K0005), Flip Arms(E0973), Large Seat (E2201), Anti Tippers(E0971), Foam Cushion(E2601), Back Cushion(E2611)
- Heavy Duty>300** (K0006), Flip Arms(E0973), Large Seat(E2202), Anti Tippers(E0971), Foam Cushion(E2601), Back Cushion(E2611)
- Extra Heavy>300** (K0007), Flip Arms(E0973), Large Seat(E2202), Anti Tippers(E0971), Foam Cushion(E2601), Back Cushion (E2611)
- Pediatric<250** (E1236), Flip Arms(E0973), Anti Tippers(E0971), Foam Cushion(E2601), Back Cushion (E2611), Seat Belt (E0978)
- Reclining<350** (K0001), Recliner (E1226), Flip Arms(E0973), Anti Tip(E0971), Foam Cushion(E2601), Back Cushion (E2611)
- Power Wheelchair Evaluation** — Evaluation will be performed to determine size and type of Power Wheelchair needed.

Wheelchair Accessories

- Transfer Board Arm Trough Elevated Legs

Bathroom Aids

- Shower Chair Transfer Bench Raised Toilet Seat
- Drop Arm Commode Commode Bariatric Commode

Hospital Beds

- Semi-Electric Foam Mattress Alt. Pressure Mattress
- Half Rails Full Rails Trapeze Bar Hoyer Lift

Orthopedic Bracing — Right Left Bilateral

- Wrist Brace Arm Sling w/Pillow Neck Brace
- Cervical Traction /Pneumatic Shoulder Immobilizer
- Knee Sleeve Knee Brace /Hinged
- Knee Brace/Hinged-ROM Knee Immobilizer Ankle Brace
- Abdominal Binder Hernia Belt Rib Belt
- Back Brace— Lumbar Lumbar/Thoracic w/side Stab.
- Walking Boot Pneumatic—Shoe Size _____ Night Splints

Crutches

- Pediatric Child Youth Adult Adult Tall Forearm

Walkers

- Front Wheeled Bariatric w/ Platform Attachment L / R
- Hemi Walker Rollator w/ Seat & Brakes Tall Extension 4"

Canes

- Three Point Quad Bariatric Quad

Respiratory

- Oxygen Concentrator—LPM _____ Freq. _____ #Tanks _____
 Delivery Method— Nasal Cannula Mask Bleed In
- CPAP BiPAP— _____ cmH2O Full Mask Nasal Mask
- Nebulizer

Other Services

- BiliBed Breast Pump Lymphedema Pump
- Tens Unit Hot/Cold Pads Heating Pad

Notes / Comments:

Physician Signature: _____ Date: _____

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