# DWO for All DME Services

*FAX COMPLETED DWO, PATIENT DEMOGRAPHICS AND SUPPORTING MEDICAL NOTES TO 207-221-9622*

**DATE OF ORDER:**_____
**DATE OF LAST FACE TO FACE:**_____

## PATIENT INFORMATION

**First Name**_____ **Last Name**_____

**Address**_____ **City**_____ **State**_____ **Zip**_____ **Phone**_____

**Date of Birth**_____ **Emergency Contact**_____ **Emergency Contact Phone**_____

## REFERRING PT OR CLINIC INFORMATION (if applicable)

**Clinic Name**_____ **Therapist Name** _____

**Clinic Address**_____ **City**_____ **State**_____ **Zip**_____

**Phone**_____ **Fax**_____

**Therapist Email** _____

## PRODUCT PRESCRIBED

☐ _____

☐ _____

☐ _____

## DIAGNOSIS

☐ **Primary ICD10 Numeric Code:**_____

☐ **Secondary ICD10 Numeric Code:**_____

## PHYSICIAN INFORMATION (Must be MD, DO, NP or PA)

*By signing and dating, I attest to prescribing the above mentioned item(s). In my professional opinion, the item(s) is both reasonable and necessary in reference to the current accepted standards of medical practice and treatment of this patient's condition. All other related treatments have been tried or considered and ruled out.*

**Physician Name**_____ **NPI#**_____ **Phone**_____ **Fax**_____

**Physician Address**_____ **City**_____ **State**_____ **Zip**_____

**Physician Signature**_____ **Date Signed**_____