

LIFE SUPPORT CUSTOMER FORM

Please read through this form and fill out accordingly.

NAME OF PATIENT:

ACCOUNT NUMBER:

HOME ADDRESS:

EQUIPMENT NEEDED:

Is this equipment necessary to sustain, restore, or supplement a vital function?

	Yes	No		Yes	No
Aerosol Tent	<input type="checkbox"/>	<input type="checkbox"/>	Intermittent Positive Pressure Breathing (IPPB)	<input type="checkbox"/>	<input type="checkbox"/>
Apnea Monitor	<input type="checkbox"/>	<input type="checkbox"/>	Motorized wheelchair	<input type="checkbox"/>	<input type="checkbox"/>
Compressor/Concentrator/Respirator	<input type="checkbox"/>	<input type="checkbox"/>	Oxygen generator	<input type="checkbox"/>	<input type="checkbox"/>
Electronic Nerve Stimulator	<input type="checkbox"/>	<input type="checkbox"/>	Pressure Pad/Pump	<input type="checkbox"/>	<input type="checkbox"/>
Electrostatic Nebulizer	<input type="checkbox"/>	<input type="checkbox"/>	Suction Machine	<input type="checkbox"/>	<input type="checkbox"/>
Hemodialysis/Kidney dialysis machine	<input type="checkbox"/>	<input type="checkbox"/>	Other, Please specify _____		

Why is the use of this equipment essential to sustain life or enhance mobility?

NAME OF PHYSICIAN:

BUSINESS PHONE:

PHYSICIAN EMAIL:

BUSINESS ADDRESS:

I hereby certify that the above information is true and correct

Signature of M.D./D.O

Physician License No.



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