

THERAPY DISCHARGE RECOMMENDATIONS

TANGLEWOOD MEDICAL SUPPLIES

PH: 1.800.460.9996 FAX: 1.888.901.6167

Patient Name: _____ Height: _____ Weight: _____

Insurance: () Medicare () Scott & White HP () Other _____

DME:

() 3N1 Commode

() *Elevated Toilet Seat* () *With Arms* () *Without Arms*

() *Shower Chair* () *With Back* () *Without Back*

() *Tub Transfer Bench*

() Slide Board

() Walker

() 2 Wheeled Rolling Walker

() Seat () Platform Attachments () Basket

() 4 Wheeled Rollator with hand brakes

() Wheelchair

() Weight: () Standard () Light

() Height: () Standard () Hemi

() Width: _____ inches

() Legs: () Regular () Elevating

() Arm Length: () Full () Desk

() Removable Arms () Anti-tippers

() Brake Extensions () Oxygen Tank Holder

() Foam Cushion () Gel Cushion

() Hospital Bed

() Hoyer Lift () Trapeze Bar

() Gel Overlay

() Alternating Pressure Pad

() Alternating Air Pressure Mattress

() *Over Bed Table*

() *ADL (Hip) Kit (Reacher, Shoe Horn, Sock Aide, Cloth Assist, Bath Brush)*

() CPM Setting: _____

Respiratory:

() Oxygen

() O2 Sat: _____ Date: _____

() Liter Flow: _____

() Portable System

() Nebulizer

Notes: _____

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PH: 254.778.4290 FAX: 254.7749108