Patient Better®
The Durable Medical Equipment Form

Form filled out by: ________________________________ Date: ________________________

Patient Name: ____________________________________ Date of Birth: __________________

Referring Physician: ____

Date of Referral: ____

ICD Codes: ____

Medical Device Name: ____

Primary Function: ____

Manufacturer: ____

Physical Address: ____

Company Phone #: ____

Model Number: ____

Date beginning use of device: Date

Did you receive the device in a timely manner? Yes No

Did you feel that you were properly educated your device? Yes No

Was the company informative about their billing? Yes No

Did you have a medical device company representative come to your home or meet you at your place of healthcare? Yes No

If Yes

Name of Representative

First and last name Contact Number

__________________ ___________________ __________________________

Was your representative they friendly, presented the company well, and informative about the steps going through the ordering process? Yes No

Did you receive you device in the mail? Yes No

If Yes

Were you informed properly on how to use the device through educational material such as YouTube videos, company websites or modules and DVD/CDs.? Yes No

Please give a detailed review of 100 words or more of your experience with your device:

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