



Patient Better

Durable Medical Equipment Information

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:
