MEDICAL EQUIPMENT DISTRIBUTION SERVICES REQUEST FORM

Note: *Requests will not be processed unless all sections are completed in full. Incomplete requests will be returned and may result in a delay.*

SECTION 1: EQUIPMENT REQUEST

Instructions:

1. *Download and save this form to your PC.*
2. *Select the type of medical equipment needed and mark the appropriate reason/s for request.*
3. *Complete the member and provider information section*.
4. *Submit this form to request@partnershiphp.org or fax the form to (707) 420-7855.*

Please note that Urgent Delivery is available for certain requests. All other items are shipped via Routine Delivery, Certified U.S Mail (ie: 2-3 days).The Certified U.S. Mail delivery person cannot leave the package unattended; an individual must be at the address to receive the package. If an individual is unhoused, please request the equipment to be shipped to their PCP site for pickup.

☐ **Pulse Oximeter**
I confirm that the patient is age 3 and older and has been diagnosed with the following (select all that apply):

☐ **Acute Respiratory Conditions at Risk of Deterioration** **(Urgent Delivery – Next Day)**	☐ Pulmonary Hypertension
☐ COVID: Home Treatment; Confirmed or Suspected to Follow For Decompensation	☐ Recurrent Pulmonary Embolism
☐ Chronic Lung Or Heart Conditions To Avoid Office Visits	☐ Auto-Immune Lung Disease
☐ Patient Is On Home Oxygen Therapy/ Home Mechanical Ventilation	☐ Interstitial Lung Disease
☐ COPD	☐ Other – please note below:
☐ Cystic Fibrosis	_____
☐ Asthma	
☐ Congestive Health Failure (CHF)	

☐ **Blood Pressure Monitor with Adult Medium Size Cuff***
(arm circumference 22-42 cm) *I confirm that the patient is age 6 or older and has been diagnosed with the following (select all that apply):*

☐ COVID: Home Treatment, confirmed or suspected to follow for decompensation	☐ Atrial Fibrillation
☐ Chronic heart conditions to avoid office visits	☐ Congestive Health Failure (CHF)
☐ Hypertension, includes pregnancy induced hypertension	☐ End Stage Renal Disease (ESRD)
☐ Preeclampsia/History of Eclampsia	☐ Pregnancy (for duration of COVID emergency)
☐ Diabetes mellitus (any type)	☐ Other - please note on form
☐ Coronary Artery Disease/Peripheral Vascular Disease	_____
☐ History of Stroke	***Alternative Equipment needed:***
	☐ **Talking BP Monitor** (For low vision member)
	*If Other Cuff Size Needed: Indicate Size:
	☐ **Small** (Arm circumference 15-24 cm)
	☐ **Large** (Arm circumference 42-48 cm)
	☐ **Extra-Large** (Arm circumference 48-61 cm)

SECTION 1: EQUIPMENT REQUEST

☐ **Digital Thermometer**
I confirm that the patient has been diagnosed with the following (select all that apply):

☐ COVID: Home Treatment; confirmed or suspected to follow for decompensation ☐ Elevated risk of contracting or spreading COVID: ☐ At risk for severe COVID (co-morbidity or over 65) ☐ Occupational exposure to general public or individuals living in congregate living environment ☐ Oncology patients on Chemotherapy ☐ Immunocompromised	☐ Infection, need to monitor for fever, unable to afford or find thermometer (Urgent delivery) ☐ Other – please note on form _____

☐ **Digital Scale (Max weight 330 lbs)** *I confirm that the patient has been diagnosed with the following (select all that apply):*

☐ Obesity (BMI greater than or equal to 30)
☐ Congestive Health Failure (CHF)
☐ Chronic Kidney Disease
☐ Other – please note on form: _____

Alternative Equipment needed:

☐ Weight 330-550 lbs: Indicate weight: _____
☐ Patient with low-vision (needs talking scale)

☐ **Smart Baby Scale (Infants must be under 40 lbs)**
I confirm that the patient is under 2 years old and has been diagnosed with the following (select all that apply):

☐ Underweight infant
☐ Failure to thrive
☐ Unexplained (Abnormal) weight loss
☐ Low Birth Weight
☐ Risk of poor weight gain
☐ Other – please note on form: _____

Important Note: This device is ***NOT*** accurate enough for quantifying breastfeeding volume but can be used for monitoring weight changes (daily or weekly). Should not be requested for monitoring volumes of individual feeds.

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☐ **Nebulizer**

I confirm that the patient has been diagnosed with the following (select all that apply):

☐ COVID: Home Treatment
☐ Asthma
☐ Chronic Obstructive Pulmonary Disease (COPD)
☐ Cystic Fibrosis
☐ Bronchopulmonary Dysplasia
☐ Bronchiectasis

☐ Replacement Parts: Indicate Part/s*: _____
☐ Pediatric Mask Needed
☐ Other – please note on form

_____

*If a replacement part is needed, please indicate the part needed on the request form.

Parts Covered: Tubing, masks, caps, chambers, baffles.

Alternative equipment needed:

☐ **Portable (Battery powered) Nebulizer** (For member who is unhoused or has no access to electricity)

☐ **Warm Steam Vaporizer**

I confirm that the patient has been diagnosed with the following (select all that apply):

☐ COVID: Home Treatment
☐ Nasal congestion due to upper respiratory infection
☐ Sinusitis
☐ Other – please note on form

_____

☐ **Cool Mist Humidifier**

I confirm that the patient age is under 12 years old and has been diagnosed with the following (select all that apply):

☐ COVID: Home Treatment
☐ Croup
☐ Pharyngitis
☐ Other – please note on form

_____

SECTION 1: EQUIPMENT REQUEST

☐ **Safer Lock Medication Lock Box, Single Lock Box**

I confirm that the patient has a need for this product based upon the following (select all that apply):

☐ Chronic Pain Syndrome
☐ Neoplasm related pain (acute)(chronic)
☐ Dorsalgia, Unspecified
☐ Other – please note on form

_____

☐ **Enuresis Alarm**

I confirm that the patient age is 14 years old or under and has been diagnosed with the following (select all that apply):

☐ Urinary Incontinence
☐ Enuresis
☐ Other – please note on form

_____

SECTION 2: MEMBER INFORMATION

Member Name:	***First Name***	***Last Name***	
Partnership Member ID# /CIN:		**Phone:**	
Member DOB:			
Member Email:	***A follow-up survey will be sent to the member. Mark "N/A" if none available or "decline" if member declines.***		
		☐ N/A ☐ Decline	
Member Language Preference:	☐ English ☐ Spanish ☐ Russian ☐ Tagalog ☐ Other, please specify: _____		

Mailing Address

Important Note: If the device should be sent to the provider office/clinic, please designate provider mailing address and indicate "Attention To" name. PLEASE CONFIRM that this address is current and up to date.

*Number and Street Name (**No P.O. Boxes**)*	*City and State*	*Zip Code*
Attn. to:		

SECTION 3: PROVIDER INFORMATION

General Guidelines:

- Members must go through their ordering clinician for instructions on how to use the equipment.
- If the patient has questions, please explain how to use the device properly. Partnership will send basic written instructions with the item, when delivered by mail.
- If the ordering clinician suspects an equipment malfunction of any sort, the ordering clinician will reach out directly to Partnership by sending an email to request@partnershiphp.org. Partnership will work to resolve the issue. *The patient should not reach out directly to Partnership; they should first work with their order clinician.*
- Set expectations on how often the patient should use the device to measure current status, how to interpret the numbers (i.e. when to call for urgent advice or go to the emergency room).
- Establish regular virtual check-ins (preferably by video) with the patient to evaluate their clinical status, the data they are collecting, and to ensure proper use of the device. The exact frequency and content of such visits would be determined based on the individual clinical scenario.

Provider Name:		
Office Name:		
Office Contact:	*Name*	*Position*

Requestor/Provider Email:	**Phone:**	**Fax:**

Date of Request: _____