



# 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](mailto: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.

<input type="checkbox"/> <b>Pulse Oximeter</b> <i>I confirm that the patient is age 3 and older and has been diagnosed with the following (select all that apply):</i>	
<input type="checkbox"/> <b>COVID: Home Treatment; Confirmed or Suspected to Follow For Decompensation (Urgent Delivery – Next Day)</b> <input type="checkbox"/> Chronic Lung Or Heart Conditions To Avoid Office Visits <input type="checkbox"/> Patient Is On Home Oxygen Therapy/ Home Mechanical Ventilation <input type="checkbox"/> COPD <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> Asthma <input type="checkbox"/> Congestive Health Failure (CHF) <input type="checkbox"/> Pulmonary Hypertension	<input type="checkbox"/> Recurrent Pulmonary Embolism <input type="checkbox"/> Auto-Immune Lung Disease <input type="checkbox"/> Interstitial Lung Disease <input type="checkbox"/> Other – please note below: <hr style="border: 0; border-top: 1px solid black; margin-top: 10px;"/>

<input type="checkbox"/> <b>Blood Pressure Monitor with Adult Medium Size Cuff*</b> <i>(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):</i>	
<input type="checkbox"/> <b>COVID: Home Treatment, confirmed or suspected to follow for decompensation</b> <input type="checkbox"/> Chronic heart conditions to avoid office visits <input type="checkbox"/> Hypertension, includes pregnancy induced hypertension <input type="checkbox"/> Preeclampsia/History of Eclampsia <input type="checkbox"/> Diabetes mellitus (any type) <input type="checkbox"/> Coronary Artery Disease/Peripheral Vascular Disease <input type="checkbox"/> History of Stroke	<input type="checkbox"/> Atrial Fibrillation <input type="checkbox"/> Congestive Health Failure (CHF) <input type="checkbox"/> End Stage Renal Disease (ESRD) <input type="checkbox"/> Pregnancy (for duration of COVID emergency) <input type="checkbox"/> Other - please note on form <hr style="border: 0; border-top: 1px solid black; margin-top: 10px;"/> <p><b>Alternative Equipment needed:</b></p> <input type="checkbox"/> <b>Talking BP Monitor</b> (For low vision member) *If Other Cuff Size Needed: Indicate Size: <input type="checkbox"/> <b>Small</b> (Arm circumference 15-24 cm) <input type="checkbox"/> <b>Large</b> (Arm circumference 42-48 cm) <input type="checkbox"/> <b>Extra-Large</b> (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 above 330 pound: Indicate weight: \_\_\_\_\_
- Patient with low-vision (needs talking scale)

**Smart Baby Scale (Infants must be under 40 pounds)**

*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.

## SECTION 1: EQUIPMENT REQUEST

**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, filters.

**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  
\_\_\_\_\_

**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  
\_\_\_\_\_

## SECTION 2: MEMBER INFORMATION

<b>Member Name:</b>	<i>First Name</i>	<i>Last Name</i>	
<b>PHC Member ID# /CIN:</b>		<b>Phone:</b>	
<b>Member DOB:</b>			
<b>Member Email:</b>	<i>A follow-up survey will be sent to the member. Mark "N/A" if none available or "decline" if member declines.</i>		
		<input type="checkbox"/> N/A <input type="checkbox"/> Decline	
<b>Member Language Preference:</b>	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Russian <input type="checkbox"/> Tagalog <input type="checkbox"/> Other, please specify: _____		
<b>Mailing Address</b>			
<b>Important Note:</b> 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.			
<i>Number and Street Name (No P.O. Boxes)</i>		<i>City and State</i>	<i>Zip Code</i>
<i>Attn. to:</i>			

## SECTION 3: PROVIDER INFORMATION

**General Guidelines:**

- Members must go through their PCP for instructions on how to use the equipment.
- If the patient has questions, please explain how to use the device properly. PHC will send basic written instructions with the item, when delivered by mail.
- If the PCP suspects an equipment malfunction of any sort, the PCP will reach out directly to PHC by sending an email to [request@partnershiphp.org](mailto:request@partnershiphp.org). PHC will work to resolve the issue. *The patient should not reach out directly to PHC; they should first work with their PCP.*
- 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.

<b>Provider Name:</b>			
<b>Office Name:</b>			
<b>Office Contact:</b>	<i>Name</i>	<i>Position</i>	
<b>Requestor/Provider Email:</b>		<b>Phone:</b>	<b>Fax:</b>

**Date of Request:** \_\_\_\_\_