Hill's Drug Store, Inc.

705 W. Kirk Pl. San Antonio, Texas 78226

Pharmacy - Ph: (210) 225.7283 Fax: (210) 226.2637

DME - Ph: (210) 226.4300 Fax: (210) 226.4334

Physician's Order Form

Date: ______________________ DOB: ______________________

Name: ____ Sex: ☐ Male ☐ Female

Address: ____ Phone: ______________________

CITY: ______________________________ State: __________ Zip: ______________

Height: ________ Weight: ________ Social Security: ______________________________

Primary Ins: ______________________ Policy #: ________________ Group #: ______________

Secondary Ins: ______________________ Policy #: ________________ Group #: ______________

Diagnosis: ____

Length of Need: ________ months (99 = lifetime) Prognosis: ☐ Poor ☐ Fair ☐ Good

Physician: __________________________ Lic #: ____________ NPI #: ______________________

Address: ____ Phone: ______________________

CITY: ______________________________ State: __________ Zip: ______________

Home Medical Equipment

- ☐ Lt. Wt. Wheelchair
- ☐ H.D. Wheelchair
- ☐ H.S. Lt. Wt. Wheelchair (High Strength Light Weight)
- ☐ Bariatric Wheelchair
- ☐ Positioning Cushion
- ☐ Elevating Leg Rest
- ☐ Brake Extensions
- ☐ Seat Belt
- ☐ Anti-Tippers
- ☐ Reclining Back
- ☐ Tens Unit
- ☐ Toilet Lift
- ☐ Patient Lift
- ☐ Lift Chair
- ☐ Hospital bed
- ☐ Trapeze bar
- ☐ Gel Overlay
- ☐ APM / Air Loss Mattress
- ☐ Bariatric Hospital Bed
- ☐ Rollator
- ☐ Walker
- ☐ Walker w/ Wheels
- ☐ V.E.D.

I herby give my consent to Hill's Drug Store,Inc. Who shall act as my legal representative/agent in communicating this written prescription, either by fax or personally presented by this patient to the provider of their choice.

______________________________________ ______________________

Physician's Signature **Date**