PLACEMENT CHANGE FORM FOR CHILDREN WITH DURABLE MEDICAL EQUIPTMENT

Case Name:_____ **Date of Placement Change:**_____

Child Name: _____ **Child DOB:** _____

Prescribing Provider Name & Phone: _____

Person Transporting DME: _____ **Primary DCM:**_____

As of this date, the next appointment with prescribing provider for the child is on_____ **at** _____

Equipment Description(s): (Include exact name e.g. nebulizer, wheelchair, etc.):

Is equipment in good working condition (yes/no & explain):

Asset/Serial Number (unique manufacturer identifier & company contact info):

Accessories Included (power cords masks, manuals, or specific attachments) & last time cleaned:

_____	_____	_____	_____
Signature Caregiver's Name	Date	Signature Caregiver's Name	Date
_____	_____	_____	_____
Signature DCM/ Transporter	Date	Signature DCM/ Transporter	Date

Caregiver: I verify that the DCM spoke with me about the information on this form. I verify that I have received the DME listed above and necessary instructions on how to use it.