



## PLAN OF CARE, ORIENTATION & DELIVERY FORM

### PATIENT NAME

Name: \_\_\_\_\_

Date of Delivery: \_\_\_\_\_

### CLINICAL INFORMATION

Diagnosis: \_\_\_\_\_

Date of Surgery: \_\_\_\_\_

Date of Injury: \_\_\_\_\_

Next Visit: \_\_\_\_\_

Physician: \_\_\_\_\_

### EQUIPMENT INFORMATION & INSTRUCTIONS

Device: \_\_\_\_\_

Serial Number: \_\_\_\_\_

Frequency: \_\_\_\_\_

Duration: \_\_\_\_\_

Follow Doctors ROM Parameters & Restrictions : \_\_\_\_\_

### ADDITIONAL INFORMATION

Assess & Discuss the following with the patient/caregiver:  **BOX IF IN ORDER**

Long Term Goal: \_\_\_\_\_

Appropriate for Use. *If No, Complete:* \_\_\_\_\_

Alert & Understands. *If No, Complete:* \_\_\_\_\_

**SAFETY ISSUES :**

- Safe Operation of Equipment
- Safe Electrical Outlet
- Clear Pathways in Home
- Do Not Walk Around While Using Equip.
- Straps Secured
- Getting In & Out of Equipment
- Personal Physical Limit

**ADDITIONAL INSTRUCTIONS :**

- Rights & Responsibilities
- Communications form
- Medicare Supplier Standards
- HIPAA Privacy Notice
- Lantz Medical Contact #'s
- Cleaning & Maintenance of Equipment
- Infection Control Tips
- Rent vs. Purchase Option for "Capped" Equip.
- Follow-up Instructions
- Complaint Hotline: (866) 236-8889

Follow-Up Visit Recommended

Follow-Up by Phone, if Needed

### SIGNATURES - Patient & Lantz Medial Rep.

I have received instructions in the use and purpose of this device. A copy of this Plan of Care may be sent to medical professionals involved in my care:

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Lantz Medical Rep Signature

**If patient is unable to sign, complete the following:**

\_\_\_\_\_  
Name of Authorized Person (Print)

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Signature