ENVIRONMENTAL / HOUSEKEEPING SCHEDULE PURSUANT TO OSHA STANDARD 29 CFR 1910.1030

Frequency of Cleaning/Decontamination

Special Area Requirements	**Surface to be Cleaned**	**Method of Decontamination**	**Frequency of Cleaning**
Warehouse	Work surface	Wipe down with Water and bleach	Once daily or after cleaning Equipment
Van	Where equipment Is kept	Not required (if equipment Is bagged)	As needed

OSHA definition of decontamination means the use of physical or chemical means to remove, inactivate, or destroy blood-borne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use, or disposal.

1910.1030(d)(4)(ii)(A)

Contaminated work surfaces shall be decontaminated with an appropriate disinfectant after completion of procedures; immediately or as soon as feasible when surfaces are overtly contaminated or after any spill of blood or other potentially infectious materials; and at the end of the work shift if the surface may have become contaminated since the last cleaning.

DME Inspection/Repair

Device:_____ **Serial#:**_____

Model#:_____ **Mfr:**_____

Date: _____ **Inspector:**_____

☐ **Inspection** ☐ **Preventive Maintenance** ☐ **Repair**

If device is electrical use orthopedic inspection/repair form

	YES	NO	Actions taken
Device in good working order			
Plates, Knobs, Screws ,Bolts present			
Controls/Switches			
Wheels, Castors, Brakes appropriate			
Cords/Straps			
Accessories/attachments in order			
vice clean & disinfected			
If new/delivered in box			
If a purchase include operating manual			
Device is patient Ready			

List Problem/If in for Repair

Services Performed

☐ **Sent back to inventory** ☐ **Sent to Manufacturer** ☐ **Incident**

EQUIPMENT HISTORY RECORD

Device: ______________________________ **Model#** ______________________________

Serial Number: ______________________________ **Manufacturer:** ______________________________

Date & Init's	Clean	Inspection	Preventive Maintenance	Repair Haz/Recall	Return to Stock (S)or Mfr. (M)	Patient/Facility Name	Pick-up Date

AUBURN PHARMACY®

"Caring for the health of you and your community"

Medicare Capped Rental Service and Inexpensive or Routinely Purchased Item Notification for Services on of after January 1, 2006

I received instructions and understand that Medicare defines the_____ that I received as being either capped rental service or an inexpensive or routinely purchased item.

___ FOR CAPPED RENTAL SERVICES:

- Medicare will pay a monthly rental fee for a period not to exceed 13 months, after which Ownership of the equipment is transferred to the Medicare beneficiary.
- After ownership of the equipment is transferred to the Medicare beneficiary, it is the beneficiary's responsibility to arrange for any required equipment service or repair.
- Examples of this type of equipment include:
  Hospital beds, wheelchairs, alternating pressure pads, air fluidized beds, nebulizers, suction pumps, continuous airway pressure (CPAP) devices, patient lifts, and trapeze bars.

___ FOR INEXPENSIVE OR ROUTINELY PURCHASED ITEMS:

- Equipment in this category can be purchased or rented; however, the total amount paid for monthly rentals cannot exceed the fee schedule purchase amount.
- Examples of this type of equipment include:
  Canes, walkers, crutches, commode chairs, low pressure and positioning equalization pads, home blood glucose monitors, seat lift mechanisms, pneumatic compressors,(lymphedema pumps), bedside rails, and traction equipment.
- I select the :

Purchase Option _____ Rental Option _____

_____ _____

Beneficiary Signature Date

Revised: 01/05/2010 sjw

DME EQUIPMENT RENTAL FORM

Rental Date	Customers Name	Address	Phone Number	SSN# or Drivers License	Equipment rented / Rx # if Medicare pt.	Deposit Amount	Emp Initial	Customer Signature on rental	Date Returned	Customer Signature upon Return:	Emp Initial

AuBurn Pharmacy

PICK-UP TICKET

Patient Information

☐ Pick-up from home or other _____

Account Number: _____

Name: _____

Address: _____

City/ST/Zip: _____

Tech: _____

Referral: _____

☐ Pick-up

Tracking Number:

Phone Number: _____

Date Of Service: _____

Ordering Physician: _____

Insurance: Primary: _____

Insurance Secondary: _____

CS Rep: _____

Equipment

Action	Qty	Product Code	HCPC	Serial/Lot #	Description		

Reason for Pick-up: ☐ Therapy completed ☐ Patient Expired date _____ ☐ Transfer to _____

☐ D/C order or AMA attached ☐ Admission to SNF ☐ Other _____

Final Bill should be sent to: _____

Billing Stop date if different that pick up date above _____

_____ _____ _____

Signature Patient/Authorized Representative **Date** **HME Tech Signature**

If Patient cannot sign, the following MUST be filled out:

_____ _____ _____

Authorized Representative Printed Name **Relationship** **Why the patient cannot sign**

_____

If the AR does not live with the patient indicate address/phone number