Physician's Order
Patient Lift

Patient Information

Name:____

Address:____

City, State, Zip:____________________________________

Medicare#:_________________________ DOB.________

Phone: _____________Height:_____ Weight: ________

PROFESSIONAL. MEDICAL HOMECARE
4869-C MEMORIAL DRIVE
STONE MOUNTAIN, GA 30083
Phone: 404-292-9190
Fax: 404-508-9225
NPI Number: XX2287131

Diagnosis	Description
__________	________________
__________	________________

Length of Need[ ]______ Months[ ]Lifetime______

Please answer the following questions.

Yes No 1.) Does the patient require assistance of more than one person in order to transfer between bed and chair, wheelchair or commode?

Yes No 2.)Without the use of the patient lift would the patient be confined?

Based upon the above information, the following items are needed by this patient for the stated length need:

Date	Check Items(s)	Quantit	HCPC	Description
		1 00	E0630	PATIENT LIFT

1, the undersigned, certify that the above prescribed equipment and/or supplies are reasonable and medically necessary as part of treatment from this patient. The need and medical necessity for the above listed equipment and/or supplies are documented in the patient's medical record and are available upon request.

____
Physician's Signature:

____
Date:

Physician Name:____________________________

NPI Number.________________________

Address:___________________________________

Phone Number:________________________

City, State, Zip:_______________________________

Fax Number.________________________