Physician's Order
Standard Wheelchair

Patient Information

Name:______________________________

Address:______________________________

City, State, Zip:______________________________

Medicare#:____________________ DOB:__________

Phone: ________________Height:_____ Weight: ________

PROFESSIONAL. MEDICAL HOMECARE
4859-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______

Yes or No — A) Does the patient have a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities (MRADLs) such as toileting, feeding, dressing, grooming and bathing in customary locations in the home?
-A mobility limitation is one that:
1) Prevents the patient from accomplishing an MRADL entirely, or
2.) Places the patient at reasonably determined heightened risk of morbidity or morality secondary to the attempts
3.) to perform an MRADL; or
4.) Prevents the patient from completing an MRADL within a reasonable time frame

Yes or No — B) Can patient's mobility limitation be sufficiently resolved by the use of an appropriately fitted cane or walker?

Yes or No — C) Does the patient's home provides adequate access between rooms, maneuvering space, and surfaces of the manual wheelchair that is provided?

Yes or No — D) Will use of a manual wheelchair significantly improve the patient's ability to participate in MRADL's and the patient will use it on a regular basis in the home?

Yes or No — E) Is the patient willing to use the manual wheelchair that is provided in the home?

Yes or No — F) Does the patient have sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day?

If no answer G — -Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.

Yes or No — G) The patient has a caregiver who is available, willing, and able to provide assistance with the wheelchair?

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

Date Needed	Quantity	HCPC	Description
	1.00	K0001 KX	Standard Wheelchair
	1.00	E0261 NU	Back Cushion for Wheelchair
	1.00	E0260 NU	Seat Cushion for Wheelchair
	1.00	K0195 RR	Leg rest for Wheelchair

I, 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:____________________