Manual Wheelchair - Medicare Questionnaire

DETAILED WRITTEN ORDER FOR DURABLE MEDICAL EQUIPMENT

Prescriber's Name (Print) ______________________ *REQUIRED* **NPI** ______________ *REQUIRED*

Order Date ______________________ *REQUIRED*

Prescriber's Signature **X** ______________________ *STAMPED SIGNATURE NOT ACCEPTED* **Signature Date** ______________ *REQUIRED*

Please sign, date and fax back to Forester Family Medical Supply.

PATIENT INFORMATION

Patient Name ______________________ **DOB** ______________

Phone#: ______________ **Height:** ______________ **WT:** ______________

DURABLE MEDICAL EQUIPMENT

1) Does the patient have a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MDADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home? ______________

2) Can the patient's mobility limitation ***not*** be sufficiently resolved by the use of an appropriately fitted can or walker? ______________

3) Does the patient's home provide adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided? ______________

4) Will the use of a manual wheelchair significantly improve the patient's ability to participate in MRADLs, and will the patient us it on a regular basis in the home? ______________

5) Has the patient expressed an unwillingness to use the manual wheelchair that is provided in the Home? ______________

6) 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 for a typical day? ______________

7) Does the patient have a caregiver who is available, willing, and able to provide assistance with the wheelchair? ______________

8) Does the patient have a cast, brace or musculoskeletal condition, which prevents 90 degree flexion of the knee, or does the patient have significant edema of the lower extremities that requires an elevation leg rest, or is a reclining back ordered? ______________

9) Does the patient have quadriplegia, a fixed hip angle, a trunk cast or brace, excessive extensor tone of the trunk muscles or a need to rest in a recumbent position two or more times during the day? ______________

10) How many hours per day does the patient usually spend in the wheelchair?

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