Written Order for Medical Equipment

Patient Name:____DOB:________________Phone:____________________

Address:____City:__________________State:______Zip:___________

Height:________Weight:________Diagnoses ICD10:____

Facility Name:_______________________________________Deliver To: ☐Home ☐Facility Discharge Date:__________

Length Of Need:__________(99=lifetime) Comments:____

	Item Description	Feature Selection	Weight Capacity
☐	Hospital Bed	☐Full Rails ☐Half Rails ☐No Rails	350lb
☐	Mattress, Foam Rubber		300lb
☐	Mattress, Dry Pressure Reducing		350lb
☐	Mattress Overlay, Gel Pressure Reducing		300lb
☐	Mattress Overlay, Alternating Pressure Pad		300lb
☐	Trapeze Bar, Free Standing		250lb

	Item Description	Standard Features Included	Weight Capacity	Width Selection
☐	Wheelchair	Elevating Leg Rests, Desk Arms	250lb	☐16" ☐18" ☐20"
☐	Wheelchair, Heavy Duty	Elevating Leg Rests, Desk Arms	251lb-300lb	☐20" ☐22"
☐	Wheelchair, Extra Heavy Duty	Elevating Leg Rests, Desk Arms	301lb-450lb	☐22" ☐24"
☐	Wheelchair, Reclining	Elevating Leg Rests, Desk Arms, Anti-tippers(pair), head extension, full reclining back	250lb	☐16" ☐18" ☐20"
☐	Wheelchair, Reclining Heavy Duty	Elevating Leg Rests, Desk Arms, Anti-tippers(pair), head extension, full reclining back, seat width 22"	251lb-350lb	☐22"
☐	Wheelchair, Transport	Foot Rests/Fixed Arm	250lb	☐19"
	☐L ☐R Anti-Tippers	☐L ☐R Brake Extensions	☐Seat Belt	☐Other:

	Item Description	Width Selection
☐	Wheelchair Seat Cushion Foam	☐16" ☐18" ☐20" ☐22" ☐24"
☐	Wheelchair Seat Cushion Gel	☐16" ☐18" ☐20" ☐22" ☐24"

	Item Description	Sling Selection	Sling Size Selection
☐	Patient Lift, Hydraulic	☐U ☐Full Body ☐ Full Body Commode	☐M ☐L ☐XL

Physician Attestation: I hereby authorize the use of this document as a legal prescription for the item indicated above. I certify that the above prescription is medically necessary and reasonable for the treatment of this patient

Physician Name:___________________________________Signature:____

Physician NPI #:___________________________________Date:______________________