

# REFERRAL FORM

## INFORMATION

Patient Name: \_\_\_\_\_

Patient Phone: (    ) \_\_\_\_\_

Address: \_\_\_\_\_

## AIDS TO DAILY LIVING

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Walker E0135                         | <input type="checkbox"/> Sidestepper E0135                | <input type="checkbox"/> Extra Wide Commode E0168  |
| <input type="checkbox"/> Hemi Walker E0135                    | <input type="checkbox"/> SM Base Quad Cane E0105          | <input type="checkbox"/> Double Arm Commode E0165  |
| <input type="checkbox"/> Walker Platform Attachment E0154     | <input type="checkbox"/> LG Base Quad Cane E0105          | <input type="checkbox"/> Bedside Commode E0163   |
| <input type="checkbox"/> Wheeled Walker E0143                 | <input type="checkbox"/> Offset Cane E0100                | <input type="checkbox"/> Confined to a single room or to one level of their home environment with no bathroom facilities |
| <input type="checkbox"/> Wheeled Walker with Seat E0143-E0156 | <input type="checkbox"/> Straight Cane E0100              | <input type="checkbox"/> Bed/Chair confined  |
| <input type="checkbox"/> Extra Wide Walker E0148              | <input type="checkbox"/> Crutches E0114                   | <input type="checkbox"/> No indoor bathroom facilities   |
| <input type="checkbox"/> Cane E0100                           | <input type="checkbox"/> Crutch Platform Attachment E0153 |  |

**For Power Mobility devices, see documentation requirements on separate form.**

## MATTRESSES, BLOOD GLUCOSE SUPPLIES, ENTERAL NUTRIENTS, HEAT & COLD THERAPIES, NEBULIZERS, ORTHOSIS(OTS), DRESSINGS

- |   |  |
|---|--|
| <input type="checkbox"/> Alternating Pressure Pad & Pump (APP) E0181                                  | <input type="checkbox"/> Ostomy Pouches and Supplies A5051-A5093 |
| <input type="checkbox"/> Gel Overlay E0185  | <input type="checkbox"/> Sitz Bath or Equipment E0160            |
| <input type="checkbox"/> Air Pressure Mattress E0186  | <input type="checkbox"/> Dressing and Wound Supplies             |
| <input type="checkbox"/> Positioning Cushion/Pillow/Wedge E0190                                       | <input type="checkbox"/> Enteral Feeding Supplies and Equipment  |
| <input type="checkbox"/> Powered Air Flotation Bed (low air loss therapy) E0193                       | <input type="checkbox"/> Enteral Formulas and Additives          |
| <input type="checkbox"/> Condition expected to last one month and patient requires aid in positioning | <input type="checkbox"/> Compression Stocking 18-30mmHg          |
| <input type="checkbox"/> Bed required to alleviate pain   | <input type="checkbox"/> Compression Stocking 30-40mmHg          |
| <input type="checkbox"/> Home Blood Glucose Monitor E0607 (non-mail order)                            | <input type="checkbox"/> Compression Stocking 40-50mmHg          |
| <input type="checkbox"/> Blood Glucose Test or Reagent Strips A4253 (non-mail order)                  | <input type="checkbox"/> Tracheostomy Supplies A7501-A7527       |
| <input type="checkbox"/> TENS Device - 2 Leads E720   | <input type="checkbox"/> Nebulizer, with Compressor E0570        |
| <input type="checkbox"/> TENS Device - 4+ Leads E730  |  |

## INCONTINENCE SUPPLIES

- Urinary Incontinence      Also list DX causing incontinence: \_\_\_\_\_
- Bowel Incontinence      Please indicate supplies requested: \_\_\_\_\_

## WHEELCHAIR

- |                                 |   |   |  |   |                             |
|---------------------------------|---|---|--|---|-----------------------------|
| <b>Type &amp; Weight Limit:</b> | <input type="checkbox"/> Standard Wheelchair (up to 250lbs.) K0001    | <input type="checkbox"/> Heavy Duty Wheelchair (over 250lbs.) K0006       |  |   |                             |
|                                 | <input type="checkbox"/> Hemi Height Wheelchair K0002                 | <input type="checkbox"/> Extra Heavy Duty Wheelchair (over 300lbs.) K0007 |  |   |                             |
| <b>Size: (Seat &amp; Width)</b> | <input type="checkbox"/> Lightweight Wheelchair (under 250lbs.) K0003 | <input type="checkbox"/> Seat Cushion E2601, E2602, E2603                 | <input type="checkbox"/> Back Cushion E2611        |   |                             |
|                                 | <input type="checkbox"/> Child  | <input type="checkbox"/> 16   | <input type="checkbox"/> 18                        | <input type="checkbox"/> 20                                     | <input type="checkbox"/> 22 |
| <b>Options:</b>                 | <input type="checkbox"/> Elevating leg rest K0195/E0990               | <input type="checkbox"/> Brake Extensions E0961                           | <input type="checkbox"/> Stump Support E1020       | <input type="checkbox"/> Super Hemi Height Under 17" K0056      |                             |
|                                 | <input type="checkbox"/> Reclining Back E1226                         | <input type="checkbox"/> Footrests w/ heel loops E0951                    | <input type="checkbox"/> Anti-tippers (pair) E0971 | <input type="checkbox"/> Amputee Setback (Bi-lateral AKA) E0959 |                             |
|                                 | <input type="checkbox"/> Tall Seat (over 21") K0056                   | <input type="checkbox"/> Quick Release Axle K0108                         | <input type="checkbox"/> Pelvic Strap E0978        | <input type="checkbox"/> Other:                                 |                             |

Condition confines client to bed or chair & wheelchair required to move about in residence.

Patient using ambulatory aid?     Yes     No    If yes, please specify: \_\_\_\_\_

- |   |  |
|---|--|
| <input type="checkbox"/> Wheelchair required for use inside of home | <input type="checkbox"/> Heavy Duty Transport Wheelchair - Gemco (over 300 lbs.) E1039 |
| Size: <input type="checkbox"/> 17 <input type="checkbox"/> 19       | <input type="checkbox"/> Standard Transport Wheelchair (up to 250 lbs.) E0138          |

## OTHER EQUIPMENT OR SUPPLIES

List or describe any other items not listed above here: \_\_\_\_\_

**PLEASE SUBMIT PERSCRIPTION ALONG WITH THIS FORM.**

**For Power Mobility Devices, see document submission requirements on our website.**