WHEELCHAIR PRESCRIPTION FORM

Physicians: ***Please fax referral and face sheet to 559.713.6012***
Patients: ***Please call 559.713.6461 to schedule***

Patient Information:

Name:	Age:	Sex: ☐ Male ☐ Female
Date of Birth:	Weight:	Height:
Address :		Phone #:

Needed Documentation: (in the past 90 days)

- ☐ History & Physical/Progress note
- ☐ Insurance
- ☐ Medlist
- ☐ PT order

Insurances Accepted (MediCal: not contracted)

☐ Medicare ☐ Cash Pay

Order:

☐ PT/OT to Eval and Treat (check one below)

- ☐ Custom Whelchair evaluation
- ☐ Durable Medical Equipment Evaluation

Medical Justificaton:

1) Length of Need: Lifetime unless specified
   ________ Months or Lifetime (circle one)

2) Diagnosis: ______________________ DX Code: ____________

3) Prognosis: ☐ Good ☐ Fair ☐ Poor

Physician's Signature: ______________________ Date: ____________

NPI # ______________________

Physician's Name (Printed) ______________________

Address: ______________________

Phone # ( ) - Fax # ( ) -

" Helping Improve Our Patients' Quality of Life "

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