PRESCRIPTION FOR MANUAL MOBILITY DEVICE

MD/DO NAME: ____________________

ADDRESS: ____________________

PHONE ____________________

FAX ____________________

NPI# ____________________

- ☐ LIGHT WHEELCHAIR
- ☐ ELEVATING WHEELCHAIR LEG RESTS
- ☐ WHEELCHAIR BACK CUSHION
- ☐ WHEELCHAIR SEAT CUSHION

PATIENT

- NAME ____________________
- DATE OF BIRTHDAY ____________________
- ADDRESS ____________________
- PHONE ____________________

DATE OF FACE TO FACE EXAMINATION ____________________

DIAGNOSES ____________________

ESPECIAL INSTRUCTIONS ____________________

PATIENT HAS EDEMA?

☐ YES ☐ NO

PATIENT REQUIRES OXYGEN?

☐ YES ☐ NO

- PATIENTS WEIGHT ____________________
- LENGHTH OF NEED = 99 (UNLESS OTHERWISE NOTED) ____________________

DATE	PHYSICIAN'S SIGNATURE