

# WHEELCHAIR-ORDER FORM

DATE OF ORDER:  
PATIENT NAME:  
ADDRESS:  
CITY: ZIP:  
PHONE:

Length of Need: \_\_\_\_\_  
DOB: \_\_\_\_\_  
HT: \_\_\_\_\_ WT: \_\_\_\_\_

ICD 10 Code1 \_\_\_\_\_ ICD 10 Code3 \_\_\_\_\_  
ICD 10 Code2 \_\_\_\_\_ ICD 10 Code4 \_\_\_\_\_

## MEDICAL EQUIPMENT ORDER:

\_\_\_ Standard: K0001                      \_\_\_ Hemi Height: K0002  
\_\_\_ Lightweight: K0003                      \_\_\_ High Strength Light Weight: K0004  
\_\_\_ Extra Heavy Duty (300lbs+): K0007                      \_\_\_ Heavy Duty (250lbs-300lbs): K0006

## Accessories:

\_\_\_ Brake Extensions: E0961                      \_\_\_ Head Rest Extension: E0966                      \_\_\_ Headrest: E0955  
\_\_\_ Reclining Back: E1226                      \_\_\_ Elevating Leg Rests: K0195                      \_\_\_ Heel Loops: E0951  
\_\_\_ Anti-Tippers: E0971                      \_\_\_ Seat/Back Cushion: E2601/E2611                      \_\_\_ Seat Belt: E0978  
\_\_\_ Seat Cushion >22": E2602                      \_\_\_ Back Cushion >22": E2612                      \_\_\_ Adjust Skin Protect Cushion: E2622

## Answer All Questions:

1. Does the patient have a mobility limitation that significantly impairs ability to participate in one or more mobility related activities of daily living (MRADL)? Y N
2. Can the patients mobility limitations be sufficiently resolved using a cane, crutches, or a walker? Y N
3. Does the patients home provide adequate access, maneuvering space, and surfaces for the use of a manual wheelchair in the home? Y N
4. Will the wheelchair significantly improve ability to participate in MRADLs and will the patient use it on a regular basis at home? Y N
5. Is the patient non-weight bearing on a lower extremity? Y N
6. Is the patient able to ambulate household distance? Y N
7. Does the patient have a caregiver who is available, willing and able to provide assistance? Y N
8. Does the patient have a cast, braces, or condition which prevents 90 degree flexation at the knee? Y N
9. Does the patient have significant edema of the lower extremities that require elevation of the legs? Y N
10. Does the patient have quadriplegia, a fixed hip angle, a trunk cast or brace, excessive extensor tone of the trunk muscles or need to rest in recumbent position two or more times during the day? Y N

Doctors Name: \_\_\_\_\_ NPI: \_\_\_\_\_  
Address: \_\_\_\_\_

Fax # \_\_\_\_\_ Phone # \_\_\_\_\_

Doctors Signature \_\_\_\_\_ Date \_\_\_\_\_