ONE SOURCE MEDICAL SOLUTIONS, INC.

ONE COMPANY. MULTIPLE SOLUTIONS.™

PRESCRIPTION FOR POWER WHEELCHAIR

CLIENT'S NAME: ______________________ CLIENT'S HICN: ____________________

DATE OF BIRTH: ______________________ HEIGHT: ________ WEIGHT: ________

ADDRESS: ___________________________ TELEPHONE: ______________________

____

PHYSICIAN OR TREATING PRACTITIONER NAME: ____________________________

EXAMINATION DATE: _________________

DIAGNOSES CODES AND CONDITIONS THAT SUPPORT THE CLAIM FOR POV:

____

____

____

____

____

____

____

TYPE OF ACCESSORIES REQUIRED:

Circle One: Oxygen Holder Elevating Leg Rest Other: ____________________

EXPECTED LENGTH OF TIME PATIENT WILL REQUIRE WHEELCHAIR:

Months Needed _____ (99 = Lifetime)

PHYSICIAN OR TREATING PRACTITIONER'S SIGNATURE: ______________________

DATE SIGNED: ______________________ UPIN: ______________________

1555 W. MOCKINGBIRD LANE, SUITE 210
DALLAS, TEXAS 75235
PHONE (214) 421-7000 FAX (214) 421-7001