****PLEASE FAX YOUR PATIENT'S DEMOGRAPHICS, CURRENT INSURANCE, TESTING INFORMATION, AND CHART NOTES ALONG WITH THIS FORM****

Seeley Medical

"ENHANCING EACH PATIENT'S QUALITY OF LIFE"

Akron • Andover • Ashtabula • Canton
Cleveland • Elyria • Poland • New Castle

Phone:1.800.473.3539
Fax: 1.866.416.3121
www.seeleymedical.com

Date:_____ Start Date: _____ Length of Need: _____

Patient Name:_____ DOB: _____

Patient Telephone:_____ Address: _____

City/State/Zip:_____ Height: _____ Weight: _____

Diagnosis: _____

HOSPITAL BEDS AND ACCESSORIES

- ☐ Hospital Bed* (fixed height with mattress and rails)
- ☐ APP* (alternating pad/pump)
- ☐ Overbed Trapeze
- ☐ Gel Mattress Overlay*
- ☐ Other _____
- ☐ Patient Lift and Sling
- ☐ Heavy Duty Hospital Bed* (with mattress and rails)
- ☐ Drop Arm Commode
- ☐ Bedside Commode

WHEELCHAIR AND ACCESSORIES*

- ☐ Lightweight Manual
- ☐ Heavy Duty Manual
- ☐ Standard Manual
- Size: ☐16 ☐18 ☐ 20 ☐ 22 ☐24
- ☐ Swing Leg Rests
- ☐ Elevated Leg Rests
- ☐ Transport Chair
- ☐ Anti Tippers
- ☐ Brake Extensions
- ☐ Wheelchair Seat/Back Cushion

BATHROOM AIDS — BATHROOM AID PRODUCTS ARE NOT COVERED BY MEDICARE

- ☐ Toilet Safety Rail
- ☐ Raised Toilet Seat
- ☐ Tub Rail
- ☐ Grab Bar
- ☐ Bath Bench
- ☐ Transfer Tub Bench

DAILY LIVING AIDS

- ☐ Adjustable Folding Walker
- ☐ Seat Lift Chair*
- ☐ Wheeled Walker (3" or 5")
- ☐ Quad Cane, Large/Small Base
- ☐ Other _____
- ☐ Heavy Duty Walker
- ☐ Wheeled Walker w/Seat
- ☐ Heavy Duty Wheeled Walker
- ☐ Heavy Duty Wheeled Walker with Seat

ENTERAL NUTRITION

☐ Oral* ☐ Pump/Poles* ☐ Pump Bags & Sets ☐ Gravity Bags & Sets ☐ Syringes for Feeding Bolus

Name of Nutrition _____ ☒ Nutrition Required

Cans Per Day_____ Calories Per Day_____

Printed Physician Name: _____ **Signature:**_____ **Date:**_____

NPI#: _____ **Address:** _____ **Phone:**_____

*** MEDICARE/MEDICAID MAY REQUIRE A COMPLETED CMN PRIOR TO DISPENSING**

REV 10/12

*** Please include signed face to face notes documenting the patient was evaluated for the item(s) ordered**