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

SEELEY MEDICAL

"Enhancing Each Patient's Quality of Life"

Akron • Andover • Ashtabula
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Phone:1.800.473.3539
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Date:_____ Start Date: _____ Length of Need: _____

Patient Name:_____ DOB: _____

Patient Telephone:_____ Address: _____

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

Diagnosis: _____

HOSPITAL BEDS AND ACCESSORIES

- ☐ Semi-Electric Bed (with mattress & rails)
- ☐ Overbed Trapeze
- ☐ Patient Lift and Sling
- ☐ Over the Bed Table (not covered by Medicare)
- ☐ *APP (alternating pad/pump)
- ☐ *Gel Mattress Overlay
- ☐ *Low Air Loss Mattress
- ☐ *Egg-crate Mattress
- ☐ Bedside Commode
- ☐ Other_____

WHEELCHAIR AND ACESSORIES

- ☐ Standard
- ☐ Lightweight
- ☐ Heavy Duty
- ☐ Size: (Please specify one) ☐ 16 ☐ 18 ☐ 20 ☐ 22 ☐ 24
- ☐ Swing Leg Rests
- ☐ Elevated Leg Rests
- ☐ Transport chair (not covered by Medicaid)
- ☐ Wheelchair Seat/Back Cushion
- ☐ Other_____

BATHROOM AIDS — BATHROOM AID PRODUCTS ARE NOT COVERED BY MEDICARE

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

DAILY LIVING AIDS

- ☐ Adjustable Folding Walker
- ☐ Wheeled Walker (3" or 5")
- ☐ Extra Wide Walker
- ☐ Heavy Duty Wheeled Walker
- ☐ *Seat Lift Chair
- ☐ Quad Cane, Large/Small Base
- ☐ Walker with Wheels and Seat
- ☐ Other_____

ENTERAL NUTRITION

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

Cans Per Day_____ Calories Per Day _____

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

Phone:_____ **NPI#** _____ **City/State/Zip Code:** _____

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