DETAILED WRITTEN ORDER FOR A MANUAL WHEELCHAIR

Patient's name: ____

Date of the order: __________________________ Start Date: ______________________________

Length of need:_______ months

General wheelchair coverage questions:

Yes / No Does the patient have a mobility limitation that significantly impairs his/her ability to participate in one of more ADLs? i.e. - toileting, feeding, dressing, grooming, bathing.

Yes/No Can this patient's mobility limitation be sufficiently resolved by the use of an appropriately fitted can or walker.

Yes/No Does the beneficiary's home provide adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair?

Yes/No Will the use of a manual wheelchair significantly improve the patient's ability to participate in ADLs?

Yes/No Will the patient use the manual wheelchair on a regular basis in the home?

Yes/No Has the patient expressed an unwillingness to use the manual wheelchair that is provided in the home?

Yes/No Does the patient have sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day?

Yes/No Does the patient have a caregiver who is available, willing, and able to provide assistance with the wheelchair?

Lightweight wheelchair questions:

Yes/No Is the patient unable to self-propel the standard weight manual wheelchair in the home?

Yes/No The patient can and will self-propel in a lightweight wheelchair.

List any limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities here.

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Physician/Practitioner's NPI #:_________________________________

Physician/Practitioner's name: ____

Physician/Practitioner's signature: ______________________________________Date:___________

**fax to 419.754.2692 with patient's demographics.