DETAILED WRITTEN ORDER FOR A ROLLATOR / WALKER

Patient name: ____

Date of the order: ____________________ Start Date: _________________________

Detailed description of the item (i.e.-wheeled walker with brakes and seat) :

____

Length of Need:_______ months

Check all that apply:

- ❑ The patient has a mobility limitation that prevents the patient from accomplishing one or more of his/her ADLs in the home.
- ❑ The patient has a mobility limitation that places him/her at reasonable determined heightened risk of morbidity or mortality secondary to the attempts to perform the ADL.
- ❑ The patient has a mobility limitation that prevents him/her from completing the ADL within a reasonable time frame.

❑yes ❑no The patient is able to safely use the walker.

❑yes ❑no The functional mobility deficit can be sufficiently resolved with use of a walker.

Physician/Pactitioner's NPI#:_____________________________

Physician/Practitioner's name: ____

Physician/Practitioner's signature: ___________________________date: ___________________

****fax to 419.754.2692 with patient's demographics.**