DETAILED WRITTEN ORDER FOR PATIENT LIFT

Patient's name: _____

Date of the order: _____ Start Date: _____

Detailed description of the item:

_____

_____

Length of Need: _____ Months

Check all that apply:

- ❑ The patient is unable to transfer self between bed and a chair, wheelchair, or commode without the use of a lift. Patient is otherwise bed or chair confined.
- ❑ The patient requires supine positioning for transfers.

Physician/Practitioner's name: _____

Physician/Practitioner's signature:_____ Date: _____

**fax to 419.754.2692 with patient's demographics.