DETAILED WRITTEN ORDER FOR SEAT LIFT MECHANISM / LIFT CHAIR

Patient's name: ____

Date of the order: ____________________ Start date: _________________________________

Detailed description of the item:

____

Length of Need: _________ Months

For patient to qualify all 4 points listed need to be met:

- ❑ The patient has severe arthritis of the hip or knee or a severe neuromuscular disease.
- ❑ The seat lift mechanism must be a part of your treatment and be prescribed to effect improvement, or arrest or retard deterioration in the patient's condition.
- ❑ The patient is completely incapable of standing up from a regular armchair or any chair in their home.
- ❑ The patient has the ability to ambulate once standing.

Physician/practitioner's name: ______________________________________

Physician/practitioner's signature: __________________________date: _________________

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