DETAILED WRITTEN ORDER FOR A CANE OR CRUTCHES

Patient name: _____

Date of the order: _____ Start Date: _____

Detailed description of the item (i.e.-cane, quad cane, crutch, wood or other) :

_____

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.

❑yes ❑no The patient is able to safely use the cane or crutches.

❑yes ❑no The functional mobility deficit can be sufficiently resolved with use of the cane or crutches.

Physician/Practitioner's name: _____

Physician/Practitioner's signature: _____date: _____

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