



**LIGHTWEIGHT WHEELCHAIR (WEIGHT LESS THAN 250 LBS)
WRITTEN ORDER PRIOR TO DELIVERY**

**PHONE: 312-738-2330
FAX: 312-738-2395**

Patient Name: _____ Patient DOB: _____
Patient Address: _____ City: _____ SS#/HICN: _____
State: _____ Zip Code: _____ Patient Telephone: _____
Height: _____ Weight: _____ Seated Hip Measurement: _____

ORDER DATE: _____ **ICD 10 CODES:** _____
Date Patient Last Seen: _____ **Discharge Date:** _____ Prognosis: _____

LIGHTWEIGHT MANUAL WHEELCHAIR (WEIGHT LESS THAN 250 LBS) (K0003, QTY: 1) | WITH: ANTI-TIPPING DEVICE (E0971, QTY: 2) HEEL LOOP (E0951, QTY: 2) and BRAKE HANDLE EXTENSIONS (E0961, QTY: 2)

ADJUSTABLE HEIGHT ARMS are necessary because the patient requires an arm height that is different than that available using nonadjustable arms and spends at least two hours per day in a wheelchair (E0973, QTY: 2)

SEAT BELT-The Patient has weak upper body muscles, upper body instability or muscle spasticity which requires use of a safety belt/pelvic strap for proper positioning (E0978 QTY 1)

Indicate which of the following conditions describe the patient. (CHECK) all that apply.

- A. Patient has a mobility limitation that significantly impairs his/her ability to participate in 1 or more mobility related activities
- B. Patient's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker
- C. Patient's home provides adequate access between rooms, maneuvering space, surfaces for use of the manual wheelchair
- D. Use of a manual wheelchair will significantly improve the patient's ability to participate in MRADLs and will be used on a regular basis in the home
- E. Patient has not expressed an unwillingness to use the manual wheelchair that is provided in the home
- F. Patient has sufficient upper extremity function, physical, mental capabilities needed to safely self-propel the manual wheelchair
- G. Patient has a caregiver who is available, willing, and able to provide assistance with the wheelchair
- AND H. Patient cannot self-propel in a standard wheelchair in the home and the patient can and does self-propel in a lightweight wheelchair**

Y N

If patient's hip measurement exceeds 19" across, please provide a NON-STANDARD SEAT FRAME WIDTH (20" WIDTH) (E2201, QTY: 1)

BACK SUPPORT CUSHION – General Use (E2611, QTY: 1)

SEAT CUSHION – General Use (E2601,E2622-SKIN PROTECTION, E2607 SKIN PROTECTION AND POSITIONING QTY: 1)

CUSHION SELECTION IS BASED ON THE QUALIFYING DIAGNOSIS BELOW (SEE ICD-10 DIAGNOSIS CODES ON BACK)

COMPLETE THE DIAGNOSIS CODES BELOW

G20. _____ Parkinson's	G35. _____ Multiple Sclerosis	G81. _____ Hemiplegia	G82. _____ Paraplegia
G30. _____ Alzheimer's	G71. _____ Muscular Dystrophy	G82. _____ Quadriplegia	L89. _____ Pressure Ulcer

Other: _____ **IF NO DIAGNOSIS CODE IS PROVIDED A E2601 GENERAL USE CUSHION WILL BE DELIVERED**

WHEELCHAIR ELEVATING LEG REST / ARTICULATING LEG REST (K0195/K0053) Indicate which of the following conditions describe the patient. (CHECK) all that apply.

1. Patient has a musculoskeletal condition or the presence of a cast or brace which prevents 90 degree flexion at the knee
2. Patient has significant edema of the lower extremities that requires having an elevating leg rest
3. Patient meets the criteria for and has a reclining back on the wheelchair

GEL / FOAM OVERLAY MATTRESS (E0185, QTY: 1) Indicate which of the following conditions describes the wheelchair patient:

1: LIMITED MOBILITY OR

2: ANY PRESSURE ULCER ON TRUNK OR PELVIS

3: COMPLETELY IMMOBILE

AND (CHECK ALL THAT APPLY):

- | | |
|----------------------------------|-----------------------------------|
| a. IMPAIRED NUTRITIONAL STATUS | c. ALTERED SENSORY PERCEPTION |
| b. FECAL OR URINARY INCONTINENCE | d. COMPROMISED CIRCULATORY STATUS |

I, the undersigned, certify that the above prescribed equipment/supplies is medically necessary as part of my treatment for this patient. In my opinion, the equipment prescribed is reasonable and necessary for accepted standards of medical practice and treatment of this patient's condition and has not been prescribed as "convenience equipment".

Physician Name: _____ Physician Telephone #: _____
Physician Address: _____ City: _____ State: _____ Zip Code: _____
Physician Signature: _____ NPI#: _____ Date: _____