WOUND CARE SOLUTIONS, INC.

HEAVYWEIGHT WHEELCHAIR (WEIGHT 300 LBS OR MORE)
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: _____ **Diagnosis:**

ORDER DATE: _____ (ICD-10 CODES): _____

Date Patient Last Seen: _____ Discharge Date: _____ Prognosis: _____

☐ **HEAVY DUTY MANUAL WHEELCHAIR** (WEIGHT 300 LBS OR MORE) *(K0007, QTY: 1)* | WITH: **ANTI-TIPPING DEVICE** *(E0971, QTY: 2)* **HEEL LOOP** *(E0951, QTY: 2)* **AND BRAKE *HANDLE EXTENSIONS*** *(E0961 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
☐ **H.** Patient weights over 300 lbs

☐ **If patient's hip measurement exceeds 19" across, please provide a NON-STANDARD SEAT FRAME WIDTH (22"OR 24" WIDTH)** *(E2202, QTY: 1)*

☐ **BACK SUPPORT CUSHION** – General Use *(E2612, QTY: 1)*

☐ **SEAT CUSHION** – **E2602 General Use, E2604 Skin Protection, E2608 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: _____

NOTE: Please maintain a copy of the WRITTEN ORDER, which must be kept on file for 7 years or longer if required by state law.