

WHEELCHAIR ACCESSORIES WRITTEN ORDER PRIOR TO DELIVERY FAX 312-738-2395 PHONE: 312-738-2330

| Patient Name: | | Patient DOB: | | |
|---|-------------------------------------|--|---------------------------------|---|
| Patient Address: | City:_ | | | |
| State: Zip Code: Patie | ent Telephone #: | SS#/HICN: | | |
| Patient HEIGHT:Patient WEIGH | | IIP MEASUREMENT: | | |
| ORDER DATE : | | Diagnosis: | | |
| DATE PATIENT LAST SEEN_ | | ICD-10 CODES | | |
| | | Prognosis: | | |
| Description: HEIGHT ADJUSTABLE ARMS | S (E0973 QTY: 2) | | | |
| Description: WHEEL LOCK BRAKE EXTER | NSIONS (HANDLE) (E0961 QTY:2) | | | |
| Patient requires a height adjustable arm | | | ositioned in the Whe | eelchair? |
| Description: RESIDUAL LIMB SUPPORTS | SYSTEM FOR WHEELCHAIR (E102 | 20 QTY:1) | LEFT: | RIGHT |
| Description: ARM TROUGH (E2209 QTY: | :1) | | LEFT: | RIGHT |
| Description: WHEEL CHAIR POSITIONING | 3 BELT/SAFETY BELT (E0978 QT) | ' : 1) | | |
| Description: OXYGEN TANK CARRIER (E. | 2208 QTY:1) | | | |
| Description: TRANSFER BOARD (REQUIF | RES A WHEEL CHAIR ON FILE) (EC | 0705 QTY:1) | | |
| | | | | |
| BACK SUPPORT CUSHION – General Us | se (E2611, QTY: 1) | | | |
| SEAT CUSHION: (E2601/E2602 Genera | l Use, E2622-Skin Protection, E26 | 607/ E2608 Skin Protection & Position | oning QTY: 1) (E2 | 602, E2608 FOR WHEELCHAIR |
| 22 INCHES AND GREATER) SEAT BELT-The Patient has weak upper I positioning (E0978 QTY 1) | body muscles, upper body instabilit | y or muscle spasticity which require | s use of a safety be | elt/pelvic strap for proper |
| CUSHION SELECTION IS BASED | ON THE QUALIFYING DIAG | NOSIS BELOW (SEE ICD-10 | DIAGNOSIS CO | ODES ON BACK) |
| | | OSIS CODES BELOV | | |
| COIVI | | | / Y | |
| G20Parkinson's G35 | Multiple Sclerosis G81 | Hemiplegia | G82 | Paraplegia |
| G30Alzheimer's G71 | G82 Muscular Dystrophy | Quadriplegia | 189 | Pressure Ulcer |
| Other: | | OSIS CODE IS PROVIDED A E2601 | GENERAL USE C | USHION WILL BE DELIVERED |
| | | | | |
| WHEELCHAIR ELEVATING LEG REST / A | RTICULATING LEG REST (KO | 195/K0053) Indicate which of the fol | lowing conditions | describe the patient. |
| | (CHECK) | all that apply. | | |
| Patient has a musculoskeletal condition | on or the presence of a cast or l | orace which prevents 90 degree | flexion at the kne | ee |
| 2. Patient has significant edema of the le | • | | | |
| 3. Patient meets the criteria for and has | a reclining back on the wheelch | nair | | |
| OFL / FOAM OVERLAY MATTRESS | (FOAOF, OTV. 4) Indiana and indian | | | |
| GEL / FOAM OVERLAY MATTRESS (| E0185, QTY: 1) Indicate which | or the following conditions a | es <i>cri</i> bes the who | eeicnair patient: |
| 1:LIMITED MOBILITY OR | 2: ANY PRESSURE | ULCER ON TRUNK OR PELV | IS | 3: COMPLETELY IMMOBILE |
| AND (CH | ECK ALL THAT APPLY): | | | |
| a. IMPAIRED NUTRITIONAL STATUS | , | ALTERED SENSORY PERCEPTI | ON | |
| | - | | | |
| b. FECAL OR URINARY INCONTINENT | | COMPROMISED CIRCULATORY | SIAIUS | |
| the undersigned, certify that the above pres n, the equipment prescribed is reasonable is not been prescribed as "convenience equ | and necessary for accepted s | s medically necessary as part standards of medical practice | of my treatmer and treatment | nt for this patient. In my opi of this patient's condition a |
| sician Name: | Phys | cian Telephone # | | |
| sician Address: | | State: | | _ |
| sician Signature: | NPI#: | Date: | | |
| | | | | |