WOUND CARE SOLUTIONS, INC.

RECLINING WHEELCHAIR (WEIGHT LESS THAN 300 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:_____Patient WEIGHT:_____

Patient HIP MEASUREMENT:_____

ORDER DATE : _____

DATE PT LAST SEEN_____ D/C DT_____

Diagnosis: _____
(ICD-10 CODES)
Prognosis _____

☐ **Description:** ***RECLINING MANUAL WHEELCHAIR (WEIGHT LESS THAN 300 LBS) Code: K0001***

-**(WITH)**-

Description: *W/C ANTI-TIPPING DEVICE (E0971) QTY: 2*

Description: *W/C ELEVATING / ARTICULATING LEG REST* (K0195 / K0053) QTY: 2

Description: *W/C MANUAL FULLY RECLINING BACK ACCESSORY* (E1226) QTY: 1

Description: *HEAD REST CUSHIONED (E0955) 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.** Patients mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker
☐ **C.** Patients 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 the patient will use 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 w/c
☐ **G.** Patient has a caregiver who is available, willing, and able to provide assistance with the wheelchair

*Elevating/ARTICULATING Leg Rest K0195/K0053 Indicate which of the following conditions describe the patient. (**CHECK**) all that apply:*

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

*Manual Fully Reclining Back Accessory E1226. (**CHECK**) Y / N:*

Is the patient at high risk for development of a pressure ulcer and is unable to perform functional weight shift -OR-
the patient utilizes intermittent catherterization for bladder management and is uanable to independently transer from the wheelchair to bed

☐ **Y** ☐ **N**

Description: ***NON-STANDARD SEAT FRAME WIDTH (20" WIDTH)*** *Code: E2201*

☐ **K.** Patients hip measurement exceeds 19" accross , requiring a non-standard seat frame width (20") **Quantity: 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

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 opin-ion, 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_____

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.