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CHAD WOJNAR R.PH., PRESIDENT
JACK LOVELAND R. PH., VICE PRESIDENT

Physician's Order Form for Walker

Type of Walker:_____ **Date Ordered:** ____/____/_____

Patient's Name: _____ **DOB:** _____/_____/_____

Patient's Address: _____

_____

Insurance ID #: _____ **Height:** ____'____" **Weight:** _____**lbs**

The physician must complete this information in order to comply with Medicare Guidelines

****Please answer <u>all</u> of the following questions**

1. Does the patient have a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADL) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home? A mobility limitation is on that: ☐ Yes ☐ No
   * Prevents the patient from accomplishing an MRADL entirely, or…
   * Places the patient at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to perform an MRADL, or…
   * Prevents the patient from completing an MRADL within a reasonable time frame.
2. Can the patient's mobility limitation be sufficiently resolved by the use of an appropriately fitted cane or crutch? ☐ Yes ☐ No
3. Will the functional mobility deficit be sufficiently resolved with the use of a walker? ☐ Yes ☐ No
4. Is the patient able to safely use the walker? ☐ Yes ☐ No

****If a walker with wheels is needed, please answer the additional questions below**

5. Does the patient have upper body weakness which prevents him/her from picking up a standard walker? ☐ Yes ☐ No
6. Does the patient have limited use of one hand, neurological disorders or severe obesity? ☐ Yes ☐ No

Diagnosis/ICD-10 Code:_____ **Length of Need:** _____

Physician Name:_____ **NPI #** _____

Physician's Address:_____

I, the undersigned, certify the above prescribed equipment and/or supplies are medically necessary as part of my treatment for this patient. In my opinion, the equipment and/or supplies prescribed are both reasonable and necessary for accepted standards of medical practice and treatment of this patient's condition. Neither the equipment and/or supplies are being prescribed as "convenience equipment".

Physician's Signature :_____**Date** ____/____/_____

LC