MEDICAL PHARMACY
1213 MAIN STREET
WILLIMANTIC, CT. 06226
PH: (860) 423-1661
F: (860) 456-2944

MEDICAL PHARMACY
WWW.MEDICALPHARMACYCT.COM\

MEDICAL PHARMACY LTC
1197 MAIN STREET
WILLIMANTIC, CT. 06226
PH: (860) 423-1661
F: (860) 423-3861

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

Physician's Order Form for Standard Weight Manual Wheelchair (K0001)

(Up to 250lbs) ☐ With Cushion ☐ With Elevating Leg Rests

Date Ordered: ____/____/_____ ☐ Initial ☐ Renewal **Date of Face to Face:** ____/____/_____

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

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

****Please answer all of the following questions****

1. The patient has a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home. A mobility limitation is one that:
   * 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.

   ☐ Yes ☐ No

2. The patient's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane or walker. ☐ Yes ☐ No

3. The patient's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided. ☐ Yes ☐ No

4. Use of a manual wheelchair will significantly improve the patient's ability to participate in MRADLs, and the patient will use it on a regular basis in the home. ☐ Yes ☐ No

5. The patient has not expressed an unwillingness to use the manual wheelchair that is provided in the home. ☐ Yes ☐ No

6. The patient has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is provided in the home during a typical day. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity, or absence of one or both upper extremities is relevant to the assessment of upper extremity function. ☐ Yes ☐ No

7. The patient has a caregiver who is available, willing, and able to provide assistance with the wheelchair. ☐ Yes ☐ No

8. Wheelchair back and seat cushion ☐ Yes ☐ No Elevating Leg Rest(s) ☐ Yes ☐ No
   Height Adjustment Arms ☐ Yes ☐ No Anti Tippers ☐ Yes ☐ No Brake Extensions ☐ Yes ☐ No

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".

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PH: (860) 423-1661
F: (860) 423-1200

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

LC