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CHAD WOJNAR R.PH., PRESIDENT

JACK LOVELAND R. PH., VICE PRESIDENT

Physician's Order Form for Cane / Crutches

Date Ordered: _____

Patient Name: _____ DOB: _____

Patient Address: _____

Insurance ID #: _____ Height: _____ Weight: _____ lbs

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

ICD- 10 Code(s): _____ Length of Need: _____

**** Please answer all questions:**

1. Does the patient have a condition that impairs ambulation? ☐ Yes ☐ No

2. If a cane is being ordered:

☐ Single Prong ☐ Quad or Three Prong

3. Does the patient require crutches?

☐ Pair of Crutches

4. Is a forearm crutch medically necessary for the patient? ☐ 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".

Physician's Signature : _____ Date _____