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

Physician's Order Form for Patient Lift-Hydraulic or Mechanical (E0630)

Date Ordered: ___/___/_____

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

Patient's Address: _____

_____

Insurance ID #: _____

Height: ____'____" Weight: _____lbs

ICD-10 Code:_____ Length of Need: _____

****Please answer the following questions:**

1. Is the transfer between a bed and a chair, wheelchair, and/or commode required? ☐ Yes ☐ No
2. Would the patient be confined without the use of the lift? ☐ 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 ____/____/_____

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