Wheelchair Written Order Request Form

Date: ________________

Provider: Sullivan's Pharmacy and Medical Supply
Address: 1 Corinth St. Roslindale, MA 02131
Phone: 617-325-0013 Fax: 617-323-8792

Patient: ____
Last *First* *ID#*

Address: ____
Street *City* *State*

Diagnosis: ______________________ **ICD-9 Code(s):** ________ ________ ________

Diagnosis: ______________________ **ICD-10 Code(s):** ________ ________ ________

Section A: Basic Qualifying Information for a Wheelchair: *Please answer each question*

Yes ☐ No ☐ 1. Does the patient have mobility limitation that significantly impairs his/her ability to participate in one or more activities of daily living such as toileting, feeding, grooming, dressing and bathing in customary locations in their home?
Yes ☐ No ☐ 2. Has a cane or walker been considered and ruled out as a solution to sufficiently resolve the patient's mobility limitation?
Yes ☐ No ☐ 3. Does the patient convey that his/her home provides adequate access and maneuvering space to use a manual wheelchair?
Yes ☐ No ☐ 4. Will the use of a manual wheelchair significantly improve the patient's ability to participate in activities of daily living and will the patient use it on a regular basis in the home?
Yes ☐ No ☐ 5. Does the patient demonstrate willingness to use the manual wheelchair in their home environment?
Yes ☐ No ☐ 6. Does the patient have sufficient upper extremity function and other physical and mental capabilities needed to safely self propel a manual wheelchair (standard or lightweight) in the home during a typical day?
Yes ☐ No ☐ 7. Does the patient have the caregiver who is available, willing, and able to provide assistance w/ the wheelchair?

Section B: Order / Statement of Need
Please Check the type of wheelchair you are ordering. *Non-standard wheelchairs require additional information. Please complete and/or check required supporting information, as applicable*

☐ **Standard Manual Wheelchair**

☐ **Standard Hemi Wheelchair** Lower Seat Height (17"-18" is required due to short stature of to enable the patient to propel the chair with their feet **Height**:________

☐ **Lightweight Wheelchair** ☐ The patient is unable to self propel a standard manual wheelchair in their home.
☐ The patient can and does self propel in a lightweight manual wheelchair

☐ **Heavy Duty Wheelchair** (*weight requirement >250lbs* **Weight**: __________

☐ **Extra Heavy Duty Wheelchair** (weight requirement >300lbs **Weight**: __________

☐ **Transport Chair** ☐ The patient is unable to self propel and has a caregiver who available and willing to assist

Accessories:

☐ Elevating Leg Rests ☐ Patient has edema of the lower extremities or knee cannot be flexed due to condition or brace/cast
☐ Wheelchair Cushion
☐ Wheelchair Oxygen Tank Holder
☐ Wheelchair Anti-Tippers

Length of Need (required): ☐ Indefinite (99 months) ☐ _____ Months

Doctor Name: ______________________ **NPI#:** ______________________

Doctor's Address: ____

Doctor's Phone #: ______________________ **Fax #:** ______________________

Sign: ______________________________________ **Date:** ______________