CONFIRMATION OF PHYSICIAN ORDER
"POWER OPERATED VEHICLE (POV)"

Patient Name:_____ DOB:_____

Address:_____

Phone:_____ HIC#_____

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Date of Order:_____ Length of need:_____

Diagnosis Code (list all):_____

Type of equipment ordered: _____

1. Does the patient require a POV to move around in their residence? Y N

2. Have all types of manual wheelchairs been considered and ruled out? Y N

3. Does the patient require a POV only for movement outside their residence? Y N

4. Is the patient capable of safely operating the controls for the POV? Y N

5. Is the patient's condition such that a wheelchair is medically necessary and the patient is unable to operate the wheelchair manually? Y N

6. Without the use of a wheelchair is the patient bed or chair confined? Y N

7. Does the patient have severe weakness of the upper extremities due to neurologic, muscular, or cardiopulmonary disease/condition? Y N

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Iola Respiratory & Home Medical
107 E Madison
Iola, KS 66749
Phone: (620) 365-3377
NPI#: 1376615310

Physician: _____
Address: _____
_____
Phone: _____
NPI #: _____

Physician Signature_____ Date:_____

Note: Documentation of the visit must accompany this form and show cause for the equipment ordered