Continuum
a CHC Solutions Company

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HOYER LIFT ORDER FORM

Please attach face sheet w/ patient demographics & insurance info

PATIENT INFORMATION

Patient Name: _____ DOB: _____/_____/_____ Gender: ☐ Male ☐ Female

Language Pref.: ☐ English ☐ Spanish ☐ Other: _____

Patient cannot accept deliveries on the following days?
☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri ☐ Sat

Height: _____ Weight:_____

Emergency Contact Name/Phone Number: _____

DIAGNOSIS

Primary Diagnosis	**Secondary Diagnosis**
ICD-10 Code: _____	**ICD-10 Code:** _____
*Non-Specified Codes will not qualify for Primary Diagnosis	

Please answer questions below

Does the patient have physical limitations that would make them bedridden without this equipment?	☐ Yes ☐ No
Does the patient require two or more people for transfers?	☐ Yes ☐ No
Is the caregiver capable of operating the Hoyer Lift?	☐ Yes ☐ No
Is the patient's home environment able to accommodate the Hoyer Lift?	☐ Yes ☐ No
Is the Hoyer Lift being used to transfer the patient from a bed to a wheelchair?	☐ Yes ☐ No

Please include (or attach) any additional information or documentation demonstrating the need for this Hoyer Lift:

Sling Type

Type	Option/Size (select one)
☐ Poly Sling	☐ With commode opening ☐ Without commode opening
☐ Mesh Sling	☐ With commode opening ☐ Without commode opening
☐ HD Full Body Sling	☐ With commode opening ☐ Without commode opening
☐ Rehab Sling with Head Support	☐ Small ☐ Medium ☐ Large
☐ Divided Leg Sling	☐ Small ☐ Medium ☐ Large
Order Date: _____/_____/_____	**Length of Need: _____ months (numeric form only)**

REFERRAL INFORMATION

Ref #: _____

Practice Name: _____ Fax: _____

Office Address: _____ Email: _____

Phone: _____ Preferred Method of Contact? ☐ Phone ☐ Fax ☐ Email

Contact Person: _____

Physician Name: _____ NPI#: _____ Phone: (_____)_____-_____ Ext. _____

Physician Signature: _____ Date: _____/_____/_____

I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing below, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed. I certify that my decision to prescribe this recommended product was solely based on my determination of medical necessity set forth herein. This document may serve as a confirmation of a verbal order and is also recorded in the patient's record.