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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?
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Mon Tues Wed Thurs Fri Sat
Emergency Contact Name/Phone Number: \_\_\_\_\_

DIAGNOSIS

Primary Diagnosis ICD-10 Code: \_\_\_\_\_ Secondary Diagnosis 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 bed ridden 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 patients 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:

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.