CHC SOLUTIONS, INC.

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WHEELCHAIR ORDER FORM

Please attach face sheet w/ patient demographics & insurance info
Please attach clinical notes or any relevant documentation

PATIENT INFORMATION

Patient Name: ______________________ DOB: ______ /______ /__________ Gender: ☐ Male ☐ Female

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

Height: ________________ Weight: __________________

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

Emergency Contact Name/Phone Number: ______________________________

DIAGNOSIS

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

Secondary Diagnosis
ICD-10 Code: ______________________

EQUIPMENT:

Size

☐ 16Dx16W ☐ 16Dx18W ☐ 16Dx20W ☐ 16Dx22W

☐ Other: ______________________________

Rehab tech will schedule an appointment at the home to measure for the chair
Hip-to-Hip Measurement Required

Add-Ons

☐ Swing Away Footrest	☐ ROHO Cushion
☐ Elevated Leg Rests	☐ Anti-Tippers
☐ Reclining Back	☐ Gel Cushions
Hip-to-Hip Measurement: ________________	**Order Date:** _____/______/______ **Length of Need:** __________ **months (Numeric Form Only)**

Please answer questions below in regard to the equipment ordered for this patient.

Is the patient able to ambulate? **If yes, how far?:** ______________________	☐ Yes ☐ No
Is the patient able to ambulate up stairs?	☐ Yes ☐ No
Is the patient able to ambulate with the use of a cane or walker?	☐ Yes ☐ No
Is the patient/caregiver able to propel the wheelchair?	☐ Yes ☐ No
Would the patient be confined to a bed or chair without equipment?	☐ Yes ☐ No
Does patient need a wheelchair to navigate their residence?	☐ Yes ☐ No

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, 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.

Call 1.800.220.5262 or visit www.chcsolutions.com for additional information.

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