Connect

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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	

Product Information:

Hoyer Lift Type: ☐ Manual ☐ Electric

Type/Size

Mesh Sling				
Full Body	☐ Medium	☐ Large	☐ 1X-Large	
Full Body w/ Commode Opening	☐ Medium	☐ Large	☐ 1X-Large	
U-shaped	☐ Medium	☐ Large		
Solid Sling				
Full Body	☐ Medium	☐ Large	☐ 1X-Large	
Divided Leg	☐ Medium	☐ Large		
U-shaped w/ Head Support	☐ Small	☐ Medium	☐ Large	☐ X-Large

Order Date: _____/_____/_____ **Length of Need: _____ months (numeric form only)**

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:

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.

Call **1.888.248.1975** or visit **www.connectchc.com** for additional information.