



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: _____ 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: _____

*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? Yes No

If yes, how far?: _____

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