BellevueHealthcare

WHEELCHAIR ORDER FORM

Customer:		Date of Birth:
Address:		
City:	State:	Zip:
Phone:	Email:	

Please attach the following as applicable:

- ☐ Demographic Sheet
- ☐ Copy of Insurance card(s)
- ☐ Test result(s)
- ☐ Rx(s)
- ☐ Physician's Note: Signed and dated note and/or medical records documenting need.

Wheelchair:

- ☐ K0001 Standard
- ☐ K0001/E1226 Standard with Full Reclining Back
- ☐ K0002 Hemi-Height
- ☐ K0003 Lightweight
- ☐ K0004 High Strength Lightweight
- ☐ K0005 Ultra Lightweight
- ☐ K0006 Heavy Duty
- ☐ K0007 Extra Heavy Duty

Anatomical Measurements:

Height: _____ Weight: _____

Knee to Heel: _____ Knee to Back: _____

Hip Width: _____ Seat-Elbow: _____

Wheelchair Dimensions:

Width: _____ Back Height: _____

Depth: _____ Seat-Floor Height: _____

Length of Need (99=lifetime): _____

Diagnosis: 1st: _____ 2nd: _____ 3rd: _____

Is the prescribed wheelchair required for the completion of MRADL?	Yes	No
Can the patient successfully ambulate in his/her home?	Yes	No
Can the patient successfully use a cane, crutches, or walker?	Yes	No
Is the wheelchair medically necessary for use in the home?	Yes	No
Can the patient propel in a standard weight wheelchair?	Yes	No
Can the patient propel in a lightweight wheelchair?	Yes	No

Notes:_____

_____

_____

Physician's Signature: _____ **Date:** _____

Physician's Name (printed): _____ **NPI:** _____

Customer Name: _____ **DOB:** _____

Options & Accessories

☐ **Seat Cushion:** Width: _____ Depth: _____
- ☐ General Use (E2601/E2602)
- ☐ Skin Protection & Positioning (E2622/E2623)**
- ☐ Skin Protection (E2603/E2604) **
- ☐ Skin Protection & Positioning Adjustable (E2624/E2625)**
- ☐ Positioning (E2605/E2606) **

**Qualifying Diagnosis required. Chart notes must support medical necessity.

☐ **Back Cushion:** Width: _____ Height: _____
- ☐ General Use (E2611/E2612)
- ☐ Positioning Posterior/Lateral (E2615/E2616)
- ☐ Positioning (E2613/E214)
- ☐ Positioning Planar Back with Lateral Supports (E2620/E2621)

☐ **Removable Armrests:**
____ Full length ____ Half length

☐ **Residual Limb Support (E1020):**
____ Right ____ Left

☐ **Elevating Leg Rests (K0195):**
- ☐ Condition or cast/brace prevents 90º knee flexion
- ☐ Has significant edema of the lower extremities
- ☐ Has medical necessity for a reclining back

☐ **Adjustable Height Armrests**

☐ **Arm Trough (E2209):**
____ Right ____ Left

☐ **Lap Tray (E0950):**
____ Full ____ Half ____ Right ____ Left

☐ **Heel Loops (E0951)** for positioning

☐ **Anti-Tippers**

☐ **Transfer Board**

☐ **Wheel Lock Extension Handle (E0961):** ____ Right ____ Left ____ Pair

☐ **Seat Belt:** ____ Auto Style ____ Velcro with D-Ring ____Quick Release ____ Positioning Belt

☐ **Other:** _____

Therapist Name (printed): _____

Therapist Signature: _____ **Date**: _____

I have examined the patient and concur with the above recommendations of the therapist.

Physician's Signature: _____ **Date**: _____

Physician's Name (printed):_____ **NPI**: _____

Please fax to your local Bellevue Healthcare location.

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