Peoria Specialty Inc.

Phone 309-693-4459 Fax 309-693-5801

PHYSICIAN ORDER - HIGH STRENGTH LIGHTWEIGHT MANUAL WHEEL

PATIENT NAME: ____

THE INFORMATION BELOW MAY NOT BE COMPLETED BY THE SUPPLIER OR ANYONE IN A FINANCIAL RELATIONSHIP WITH THE SUPPLIER.

ESTIMATED LENGTH OF NEED: ________________ (LIFETIME = 99)

DIAGNOSIS CODES: ________ ________ ________ ________

TYPE OF WHEELCHAIR ORDERED: ☐ **HIGH STRENGTH LIGHTWEIGHT MANUAL WHEELCH**

ACCESSORIES **WITH** HCPCS CODE:

☐ ANTI-TIPPERS E0971

☐ EXTRA LONG HAN

☐ PELVIC BELT E0978

☐ ELEVATING LEG RESTS E0990 QUANTITY ( )

☐ DETACHABLE ARI ADJ HEIGHT E097

☐ EXTRA WIDE SEAT FRAME GREATER THAN OR EQUAL TO 20 IN AND LESS THAN

☐ OTHER: ____

1. Does the patient have a mobility limitation that significantly impairs their ability to perform on or more **MRADL**s? **MRADL** = **M**obility **R**elated **A**ctivities of **D**aily **L**iving (I.e. toileting, feeding, dressing, grooming or bathing in customary areas within the home) ☐ YES ☐
2. Will this provision of a manual wheelchair significantly improve the patient's ability to perform **MRADL**s? ☐ YES ☐
3. Is there a **CONSISTENT CAREGIVER** available to assist the patient with the use of the manual wheelchair? ☐ YES ☐
4. Is the patient (or caregiver) willing to operate the wheelchair **SAFELY**? ☐ YES ☐
5. Can the mobility limitation be resolved with the use of an appropriately fitted **CANE** or **WALKER**? ☐ YES ☐
6. Does the patient **TYPICAL HOME ENVIRONMENT** support the use of a manual wheelchair? ☐ YES ☐
7. Does the patient have sufficient use of their **UPPER EXTREMITIES** to **SELF-PROPEL** a manual wheelchair? ☐ YES ☐
8. Can the patient adequately self-propel a **STANDARD** manual wheelchair? ☐ YES ☐
9. Can the patient able to adequately self-propel a **LIGHTWEIGHT** manual W/C? ☐ YES ☐
10. Does the patient frequently engage in activities within the home that CANNOT be accomplished with a standard or lightweight wheelchair? ☐ YES ☐
11. Does the patient require a NON-STANDARD seat width, depth or height AND spend at least 2 hours a day in the wheelchair? ☐ YES ☐

Physician Name: ________________________ NPI: ____________

Physician Signature: ___________________________________ Date:______________________________

CHAIR

IAIR K0004

IDGRIPS E0961

MREST WITH
3 QUANTITY ( )

N 24 E2201

____

NO

NO

NO

NO

NO

NO

NO

NO

NO

NO

NO