Mobility

Rx

Prescriber: _____
Address: _____
_____
Telephone #: _____
Fax #: _____
NPI #: _____
Diagnosis Code(s): _____
_____

Patient's Name: _____ D.O.B.: _____

Insurance ID#: _____ Length of Need: *Lifetime*

EQUIPMENT

- Seat Lift
- Heavy Duty Seat Lift
- Rollator
- Heavy Duty Rollator
- Power Mobility Device / Scooter
- Heavy Duty Power Mobility Device / Heavy Duty Scooter
- Power Wheelchair
- Heavy Duty Power Wheelchair
- Bath Chair
- Manual Wheelchair
- Other/Description: _____

SERVICES

- Seating Evaluation / Equipment Dispensation
- Diagnose and Repair

Prescriber's

Signature:X _____ Date: _____

Required Repairs after Diagnostic Check / After Prescriber's Signature

11/11/2020