Phone: 586-778-2500
Fax: 866-565-5190

Written Order Prior to Delivery

Manual Wheelchair Accessories & Cushions

Per Medicare requirements, a **SIGNED PHYSICIAN'S ORDER is required PRIOR TO delivery**.
Please answer all questions below and return to Renaissance Medical. In addition, please make sure a signed copy is kept in your patient's file. As of **July 1, 2013**, you must forward documentation of a face to face evaluation before delivery can be made.

Patient Full Name: _____ Date of Birth: ____/____/_____

Address City/St/Zip:_____

Medicare # _____ Other Ins Type & #_____

Referring Facility/Name:_____ Contact Name: _____

Related Diagnosis: _____ Length of Need: _____ (99=Lifetime)

Deliver To: ❑ Facility ❑ Home Req. Delivery Date: _____ Approx Time: _____ Discharge Date: _____

1. Is your patient susceptible to Decubitus? _____ Y _____ N
2. Is your patient wheelchair confined? _____ Y _____ N
3. Does your patient have Decubitus Ulcers or a past history of Decubitus Ulcers on the area of contact with the seating surface? **Lower back, sacrum (707.03), hip (707.04), and buttock (707.05)**.? _____Y _____N
4. Does your patient have absent or impaired sensation in the area of contact and/or inability to carry out a functional weight shift due to one of the following dx: quadriplegia or paraplegia due to spinal cord injury or brain injury **(344.00-344.1, 344.09)**, other spinal cord disease**(336.0-336.3)**, MS **(340),** other demyelinating disease **(341.0-341.9),** cerebral palsy **(343.0-343.9),** anterior horn cell diseases including ALS **(335.0-335.21,335.23-335.9),** post polio paralysis **(138),** spina bifida **(741.00-741.93),** childhood cerebral degeneration **(330.0-330.9),** Alzheimers **(331.0),** Parkinsons **(332.0)**? _____Y _____N
5. Does your patient have any significant postural asymmetries due to the above or one of the following dx: monoplegia of the lower limb **(344.30-344.32,438.40-438.42)** or hemiplegia **(342.00-342.92, 438.20-438.22)** due to stroke, traumatic brain injury, or other etiology, muscular dystrophy **(359.0,359.1)** torsion dystonias **(333.4, 333.6 333.7),** spinocrebellar disease **(334.0-334.9)**? _____Y _____N

❑ General Use Foam (E2601, E2602, E261 1, E2612)	Requires 1 and 2 to be YES	Width:____ Depth: ____
❑ Gel Cushion (E2603, E2604)	Requires 1, 2 and 3 to be YES	
❑ Skin Protection Cushion, Adj (E2622 – E2623)	Requires 1 and 2 to be YES AND 4 OR 5 to be YES	
❑ ROHO / STAR Cushion (E2622, E2623)	Requires 1 and 2 to be YES AND 4 OR 5 to be YES	
❑ Positioning Seat Cushion (E2605, E2606,)	Requires 1 and 2 to be YES AND 4 OR 5 to be YES	
❑ Hardshell Type Backs (E2613 - E2616)	Requires 1 and 2 to be YES AND 4 OR 5 to be YES	

- ❑ One Arm Drive Attachment (E0958)
- ❑ Shoulder Harness / Strap (E0960)
- ❑ Wheel Lock Brake Extension Handle (E0961) ❑Left ❑Right
- ❑ Hand Rim with Projections (E0967)
- ❑ Anti Tipping Device (E0971) ❑Rear ❑Front
- ❑ Adjustable Height, Detachable Armrest (E0973) ❑Left ❑Right
- ❑ Arm Trough (E2209) ❑Left ❑Right
- ❑ Mounting Hardware for Arm Trough (E1028) Qty: _____
- ❑ Positioning Belt / Safety Belt / Pelvic Strap (E0978)
- ❑ Residual Limb Support for Wheelchair (E1020) ❑Left ❑Right
- ❑ Elevating Legrest (K0195)
- ❑ Elevating Articulating Legrest (E0053)
- ❑ Sliding Board (E0705)
- ❑ Rollabout /Chairs (Geri Chair) (E1031)
- ❑ Headrest (E0955)
- ❑ Headrest Mounting Hardware (E1028)
- ❑ Reclining Back for Wheelchair (E1226)
- ❑ Transport Chair, Adult Size up to 300LB (E1038)
- ❑ Transport Chair, Adult Size Heavy Duty Gt 300LB (E1039)
- ❑ ½ Lap Tray (E0950) ❑Left ❑Right
- ❑ Full Lap Tray (E0950)
- ❑ Tilt-In-Space Feature (E1161) Need full evaluation to justify
- ❑ Special Sized Wheelchair Seat Height (E1296)
- ❑ Special Sized Wheelchair Seat Width (E2201)
- ❑ Manual Wheelchair Back Upholstery – Replacement Only (E0982)
- ❑ Manual Wheelchair Seat Upholstery – Replacement Only (E0981)
- ❑ Oxygen Holder for Wheelchair (E2208)
- ❑ Solid Seat Insert (E0992)

Ordering Physician, PA, or Nurse Practitioner Name (Please Print): _____

Ordering Physician, PA, or Nurse Practitioner Signature: _____ Date: _____

NPI: _____

Please Fax This Page with Patient Demographics To: 1•866•565•5190