NORTHEAST MEDICAL PRODUCTS, INC
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TRANSPORT CHAIR ORDER FORM

Patient Name _____ DOB _____

Address _____

Diagnosis codes _____ Length of Need: _____

Height_____Weight_____Start Date_____

Equipment ordered:

_____ E1038 TRANSPORT CHAIR

Coverage Questions for Transport Chair:

Y N Does the patient have a mobility limitation that significantly impairs his/her ability to participate in one or more mobility related activities of daily living such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home?

Y N Can the patient's mobility limitation be sufficiently resolved by the use of an appropriately fitted cane or walker?

Y N Does the patient's home provide adequate access between rooms, maneuvering space, and surfaces for use of the transport chair that is being provided?

Y N Will the use of the transport chair significantly improve the patient's ability to participate in MRADLs and the patient will use it on a regular basis in the home?

Y N Has the patient expressed an unwillingness to use the transport chair that is provided in the home?

Y N Does the patient have a caregiver who is providing 24 hour a day care, and is willing and able to provide assistance with the transport chair?

Y N Is the patient unable to use a wheelchair?

PLEASE PROVIDE A COPY OF THE CLINICAL NOTES FROM THE FACE-TO-FACE VISIT
(Please be sure to sign, date, and NPI the end of the patient notes)

Physician Name_____

Address _____

Phone _____ Fax _____

NPI _____

_____
Physician Signature Date