MEDICAL EQUIPMENT SCRIPT

Please send completed form along with patient's face sheet & applicable clinical notes

PHONE: (718) 854-5501 FAX: (718) 369-5858

Patient Name:	**Emergency Contact Information:**
Address: _____ _____	**Primary Insurance & ID #:**
Phone:	**Secondary Insurance & ID #:**
Date of Birth:_____/_____/_____ ☐M ☐F	**Deliver To: ☐ Home ☐Facility Room#____ D/C Date_____**
Height: Weight:	**Facility Name:_____**
Diagnosis:	**Contact Person Name:_____**
Infectious Disease Present? ☐ Yes ☐ No	**Contact Person Phone # & Ext._____**

WHEELCHAIRS	**WALKERS & CRUTCHES**	***HOSPITAL BEDS & MATTRESS ACCESSORIES***
Wheelchair Size: Width____Depth____ ☐Manual Standard ☐Heavy Duty *(250lbs. Plus)* ☐Light Weight ☐Hemi ☐Recline ☐High Back ☐Elevating Leg Rest *Progress note required	☐ Walker Standard ☐ With Wheels ☐ Junior *(Under 5ft)* ☐ Walker Extension *(6ft Plus)* ☐ Heavy Duty *(300lbs. Plus)* ☐ Rolling Walker w/ Seat & Break *(Rollator)* ☐ Platform Attachment ☐ Crutches Alum. *Adult☐ Youth☐Tall☐* ☐ Forearm Crutches *Adult☐ Youth☐Tall☐* ☐ Adjustable Alum. Cane ☐ Adjustable Alum. Cane Off Set ☐ Quad Cane Small Base____Large Base____	☐ Semi Electric Hospital Bed ☐ Heavy Duty *(350lbs. Plus)* ☐ Gel Overlay ☐ Low Air Loss Mattress ☐ Alt. Pressure Mattress ☐ Half Side Rails ☐ Full Rails ☐ Hoyer Lift *Progress note required

WHEELCHAIR ACCESSORIES	**BATHROOM EQUIPMENT**
☐Anti-Tippers QTY: _____ ☐Brake Ext. QTY: _____ ☐Seat Belt (Auto_____Velcro_____) ☐Solid Seat Insert ☐Transfer Board ☐Seat Cushion: Gel_____Foam _____ ☐Back Cushion	☐ Commode ☐ Drop Arm ☐ Heavy Duty *(300lbs. Plus)* ☐ Raised Toilet Seat ☐ With Arms ($39.50) ☐ Without Arms($34.00) ☐ Bath Chair With Back ☐ Without Back ☐ Tub Transfer Bench ($55.00)

Start Date:_____/_____/_____

Indicates Additional Documentation will be required for Medicare Orders

Prescriber Name:	**Address:** _____ _____	**Phone #:** **Fax #:**
Prescriber Signature **X_____**	**Date:** _____/_____/_____	**Prescriber NPI #:**