Phone (800) 430-0539 Fax to (800) 430-0255

***Please include patient chart notes, demographic sheet, insurance info**

Order Date _____

ORBIT medical

Patient Information

Name _____ DOB _____ Phone _____

Address _____ City _____ State _____ ZIP _____

HT _____ WT _____ Insurance _____ Policy Number _____

Manual Wheelchairs

☐ Standard Hemi Wheelchair w/ anti-tippers, seat belt, brake extensions - K0002

☐ Lightweight Manual Wheelchair w/ anti-tippers, seat belt, brake extensions - K0003

☐ High-Strength LW Wheelchair w/ anti-tippers, seat belt, brake extensions - K0004 Unable to use a standard or LW wheelchair to complete

☐ HD Manual Wheelchair (pt +251lbs) w/ anti-tippers, seat belt, brake extensions - K0006

(pt +301 lbs) w/ anti-tippers, seat belt, brake extensions - K0007

Standard Options: ☐ Elevated Leg Rests ☐ Adjustable Height Arm Rests

High Back Options: ☐ Fully Reclining High Back (E1226) ☐ Cushioned Head Rest (only on high back) (E0955)

Cushions: ☐ Foam Seat Cushion ☐ Gel Seat Cushion ☐ Air cushion ☐ Back Cushion

*note– Lightweight manual wheelchair is typically only covered by insurance when the patient is unable to self propel a standard wheelchair to complete

Hospital Beds

☐ Semi-Electric Hospital Bed ☐ Bariatric Bed (pt +351lbs) ☐ Full-Electric Hospital Bed ($450 upgrade fee)

☐ Gel Overlay (E0185)

Overlay Qualifications: ☐ Ulcer *or* ☐ Partially Immobile *and*

☐ Fecal or Urinary incontinence ☐ Altered sensory perception ☐ Compromised circulatory status ☐ Impaired nutritional status

Mobility

☐ Motorized Wheelchair ☐ Walker

☐ 3 in 1 Commode ☐ Rollator Walker

☐ _____ ☐ _____

Other

Respiratory

☐ 24 Hr Oxygen ☐ Nocturnal Oxygen ☐ Overnight Oximetry

Sat Level _____% LPM _____ Date Tested _____

☐ Concentrator ☐ Portables ☐ Conserving Device ☐ Via Nasal Cannula

☐ Notes _____

Qualification

Start Date: _____ Length of Need 99 (in months, 99=lifetime)

- ☐ E11.9 - DM wo cmp nt st uncntr
- ☐ E78.5 - Hyperlipidemia NEC/NOS
- ☐ E66.01 - Morbid Obesity
- ☐ D64.9 - Anemia NOS
- ☐ F03.90 - Unspecified Dementia wo behav dis
- ☐ G30.9 - Alzheimer's Disease
- ☐ G20 - Parkinson's
- ☐ G35 - Multiple Sclerosis
- ☐ G81.90 - Unsp Hemiplegia unspf side
- ☐ G63 - Neuropathy in other dis
- ☐ I10 - Hypertension NOS
- ☐ I25.10 - Coronary Artery Disease
- ☐ _____
- ☐ _____
- ☐ I48.91 - Atrial Fibrillation
- ☐ I50.9 - CHF NOS
- ☐ I67.89 - CVA
- ☐ I73.9 - Peripheral Vascular Disease NOS
- ☐ J18.9 - Pneumonia, organism NOS
- ☐ J44.9 - COPD
- ☐ N18.6 - End Stage Renal Disease
- ☐ N18.9 - Chronic Kidney Disease NOS
- ☐ L89.159 - Pressure Ulcer, lower back
- ☐ L89.209 - Pressure Ulcer Hip
- ☐ L89.309 - Pressure Ulcer Buttocks
- ☐ M06.9 - Rheumatoid Arthritis
- ☐ _____
- ☐ _____
- ☐ M19.90 - Osteoarthritis NOS-unspec
- ☐ R26.2 - Difficulty in walking
- ☐ M48.00 - Spinal Stenosis
- ☐ M54.5 - Lumbago
- ☐ M54.9 - Backache NOS
- ☐ R09.02 - Hypoxemia
- ☐ M62.81 - Muscle Weakness - general
- ☐ M81.0 - Osteoporosis NOS
- ☐ R26.9 - Abnormality of Gait
- ☐ R60.9 - Edema
- ☐ R06.02 - Shortness of Breath
- ☐ Z91.81 - Personal Fall History
- ☐ _____
- ☐ _____

Physician Information

Name _____ NPI _____ Phone _____ Fax _____

Address _____ City _____ State _____ ZIP _____

Physician Signature _____ Date _____