INDEPENDENCE ON WHEELS

Call (877) 849-0775 with any questions, or for assistance, in completing this form!

Patient Name: _____ **Start Date**: _____

Patient's Height: _____ Weight: _____Physician's Name: _____

Diagnoses (Include ICD-10): _____

Equipment Order (Check all appropriate boxes)

Please also send Patient's demographic sheet along with this order

Seating

- ☐ Special Needs Car Seat
- ☐ Activity Chair
- ☐ Push chair/stroller
- ☐ Other:

_____
_____
_____

Lying

- ☐ Safety Bed
- ☐ Hospital Grade Crib
- ☐ Group 2 Support Surface (i.e. low air loss mattress)
- ☐ Other:

_____
_____

Mobility

- ☐ Gait Trainer/Walker*
- ☐ Crawler*
- ☐ Stander/Standing Frame*
- ☐ Ultra-Light Manual Wheelchair*
- ☐ Tilt-In-Space Manual Wheelchair*
- ☐ Power Wheelchair*
- ☐ Wheelchair seat and/or back cushion (off-the-shelf)
- ☐ Wheelchair seat and/or back cushion (custom molded/custom planar)*
- ☐ High Frequency Chest Oscillator/Afflovest
- ☐ Other:

_____
_____
_____

Bath Safety

- ☐ Adaptive Bath Chair
- ☐ Bath Lift
- ☐ Rolling Shower Chair
- ☐ Toileting System
- ☐ Bath Transfer System
- ☐ Other:

_____
_____
_____

Communication

- ☐ Dedicated Speech Generating Device**
- ☐ Other:

_____
_____

☐ Physical, Occupational, or Speech Therapist Evaluation Needed

**These devices require either a PT or OT evaluation from someone who does not have a financial relationship with IOW*

***These devices require a SLP evaluation from someone who does not have a financial relationship with IOW*

Length of Need: _____(99 = lifetime) Discharge Date (if applicable):_____

_____ _____

Physician's/Physician's Assistant/Nurse Practitioner Signature Signature Date

"Cannot be stamped, must be hand written"

Fax Order To: (855) 242-4778