



NAME OF FACILITY: _____
REFERRAL CONTACT: _____ PHONE: _____

Account Executive (circle one) - Frank Trammell - (704) 579-7070; Ashley Kemp - (704) 564-6982; Adrian Johnson - (704) 698-5296; Main Office (704) 846-7503; Main Fax (704) 846-7911

General Equipment Detailed Written Order Prior to Delivery (DWOPD)

PATIENT'S NAME: _____ PHONE: _____
PATIENT'S HEIGHT: _____ WEIGHT: _____ DATE OF BIRTH: _____
SNF/REHAB/HOSPITAL DISCHARGE DATE: _____
PRIMARY CARE PHYSICIAN'S NAME: _____

DIAGNOSIS: _____

EQUIPMENT NEEDED: (check items)

The items listed below DO NOT require office visit notes, but require a physician's VERBAL or SIGNED order prior to delivery.

- SINGLE POINT CANE
- WALKER
- ROLLATOR (walker with wheels and seat)
- CRUTCHES
- RAISED TOILET SEAT
- TRANSFER BENCH
- QUAD CANE - BASE SIZE: S L
- WALKER WITH WHEELS
- PLATFORM ATTACHMENT (check one below):
 - R L Bilateral
- SHOWER CHAIR (seat with back support)
- COMPRESSION HOSE _____ MMHG

The items listed below REQUIRE office visit notes & a physician's VERBAL or SIGNED order prior to delivery.

- BEDSIDE COMMODE
- TRAPEZE BAR
- POWER WHEELCHAIR
- PT/OT TO EVALUATE & TREAT FOR POWER MOBILITY
- DROP ARM COMMODE
- SCOOTER

The items listed below REQUIRE office visit notes & a physician's SIGNED order prior to delivery.

- GEL OR GEL-LIKE PRESSURE PAD FOR MATTRESS, STANDARD MATTRESS LENGTH AND WIDTH
- PATIENT LIFT, HYDRAULIC OR MECHANICAL, INCLUDES SLING
- POWERED PRESSURE-REDUCING AIR MATTRESS (LOW AIR LOSS MATTRESS)
of ulcers: _____; stage(s) of ulcers: _____
- SEMI ELECTRIC HOSPITAL BED WITH MATTRESS AND SIDE RAILS
- SEMI ELECTRIC HOSPITAL BED WITH MATTRESS WITHOUT SIDE RAILS* - (E0294)
*Recommended for restraint free facilities
- SEAT LIFT MECHANISM INCORPORATED INTO A COMBINATION LIFT-CHAIR MECHANISM (LIFT CHAIR)

Name of Referring Physician (Print): _____ Length of Need: _____

Physician's Signature: _____ Signature Date: _____
(if not available, must have verbal order or doctor's order)

NPI: _____

Start/Date of Order*: _____

SUBSTITUTION PERMITTED TO PROVIDE A QUALIFYING SERVICE.

* - MUST have start/date of order in addition to physician's signature date.