CAROLINA'S HOME MEDICAL EQUIPMENT INCORPORATED

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

Evaluation for Mobility Needs Order

PATIENT'S NAME: _____ PHONE: _____

PATIENT'S HEIGHT: _____ WEIGHT: _____ DATE OF BIRTH: _____

SNF/REHAB/HOSPITAL DISCHARGE DATE: _____

PRIMARY CARE PHYSICIAN'S NAME: _____

DIAGNOSIS: _____

Choose one below:

□ PT OR OT TO EVALUATE & TREAT FOR MOBILITY NEEDS IN WHEELCHAIR SEATING CLINIC OR BY HOME HEALTH

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

Physician's Signature: _____

(if not available, must have verbal order or doctor's order)

NPI: _____ **Start/Date of Order*:** _____

*** - MUST have start/date of order**