CAROLINA'S HOME MEDICAL EQUIPMENT INCORPORATED

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

Account Executive - Ashley Kemp; Phone (704) 564-6982; Office (704) 846-7503; Fax (704) 846-7911

Complex Rehabilitation Technology Order Form

PATIENT'S NAME: _____ PHONE: _____

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

SNF/REHAB/HOSPITAL DISCHARGE DATE (if applicable): _____

HOME HEALTH INVOLVED IN PATIENT'S CARE (if applicable): _____

HOME HEALTH PHONE NUMBER: _____

DIAGNOSIS: _____

INSURANCE -

Primary Insurance Name: _____ **Policy #**_____

Secondary Insurance Name: _____ **Policy #**_____

EQUIPMENT NEEDED: (please check items)

□ POWER WHEELCHAIR (Group 2 Single Power, Group 3, and Group 4)
□ MANUAL WHEELCHAIR (Ultra Lightweight Manual Wheelchair, K0005)
□ TILT IN SPACE MANUAL WHEELCHAIR (E1161)
□ CUSTOM PEDIATRIC WHEELCHAIR

□ BATH CHAIR*
□ ACTIVITY CHAIR*
□ CAR SEAT*
□ STANDER*
□ GAIT TRAINER*
□ PEDIATRIC SPECIALTY BED*

* = Patient MUST have Medicaid as primary or secondary insurance.

□ VEHICLE LIFT
□ STAIR LIFT
□ CEILING LIFT
□ PORTABLE RAMP
□ HOME ACCESS RAMP

The above items require an evaluation with a PT or OT, which we will coordinate. By signing the form, you agree to have a Physical OR Occupational Thereapist evaluate and treat for mobility needs in either a wheelchair seating clinic or by home health.

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

Physician's Signature: _____

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

SUBSTITUTION PERMITTED TO PROVIDE A QUALIFYING SERVICE.

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

Please send demographics, and recent patient office visit notes (if available) with the order.