NAME OF FACILITY: ________________________________
REFERRAL CONTACT: _____________ PHONE: ______________

Account Executive - Adrian Johnson; Phone (704) 698-5296; Office (704) 846-7503; 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
□ SHOWER CHAIR (seat with back support)
□ COMPRESSION HOSE __________ MMHG
□ QUAD CANE - BASE SIZE: S L
□ WALKER WITH WHEELS
□ HEMI WALKER
□ PLATFORM ATTACHMENT (check one below):
□ R □ L □ Bilateral
□ LEG EXTENSTIONS FOR WALKER (SET OF 4) (FOR PATIENTS 6' OR TALLER.)
□ TRANSFER BOARD: 24" 30"

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

□ BEDSIDE COMMODE
□ DROP ARM COMMODE
□ TRAPEZE BAR
□ POWER WHEELCHAIR
□ SCOOTER
□ PT OR OT TO EVALUATE & TREAT FOR MOBILITY NEEDS (Choose One):
□ HOME HEALTH OR □ SEATING CLINIC

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

□ DRY PRESSURE MATTRESS
□ 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: (Choose one option:)
□ MATTRESS & SIDE RAILS □ NO MATTRESS & SIDE RAILS
□ MATTRESS & NO SIDE RAILS □ NO MATTRESS & NO SIDE RAILS
□ SEAT LIFT MECHANISM INCORPORATED INTO A COMBINATION LIFT-CHAIR MECHANISM (LIFT CHAIR)

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*:** ____________

SUBSTITUTION PERMITTED TO PROVIDE A QUALIFYING SERVICE.

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