



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

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

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**