DWO for Mobility Services

FAX COMPLETED DWO, PATIENT DEMOGRAPHICS AND SUPPORTING MEDICAL NOTES TO 207-221-9622

DATE OF ORDER:_____
DATE OF LAST FACE TO FACE:_____

PATIENT INFORMATION

First Name_____ **Last Name**_____

Address_____ **City**_____ **State**_____ **Zip**_____ **Phone**_____

Date of Birth_____ **Emergency Contact**_____ **Emergency Contact Phone**_____

REFERRING PT OR CLINIC INFORMATION (if applicable)

Clinic Name_____ **Therapist Name** _____

Clinic Address_____ **City**_____ **State**_____ **Zip**_____

Phone_____ **Fax**_____ **Therapist Email**_____

PRODUCT PRESCRIBED

◯ Walker with wheels, no seat ◯ Walker, no wheels, no seat

◯ Crutches, axillary ◯ Crutches, forearm

◯ Cane, single point ◯ Cane, quad

◯ Other mobility item, be specific_____

ANSWER ALL QUESTIONS BELOW (#'S 4 AND 5 FOR WALKERS ONLY)

☐ Yes ☐ No 1. Is the patient ambulation impaired?

☐ Yes ☐ No 2. Does the patient have a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADL) in the home?

☐ Yes ☐ No 3. Does the patient have a mobility limitation that cannot be sufficiently resolved by a cane or crutches?

☐ Yes ☐ No 4. Does the patient have a mobility deficit that can be resolved with a walker?

☐ Yes ☐ No 5. Can the patient safely use a walker?

DIAGNOSIS

◯ **Primary ICD10 Numeric Code:**_____ ◯ **Secondary ICD10 Numeric Code:**_____

PHYSICIAN INFORMATION (Must be MD, DO, NP or PA)

By signing and dating, I attest to prescribing the above mentioned item(s). In my professional opinion, the item(s) is both reasonable and necessary in reference to the current accepted standards of medical practice and treatment of this patient's condition. All other related treatments have been tried or considered and ruled out.

Physician Name_____ **NPI#**_____ **Phone**_____ **Fax**_____

Physician Address_____ **City**_____ **State**_____ **Zip**_____

Physician Signature_____ **Date Signed**_____