Mobility & More

251 N. Trade St.
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Phone/Fax 704-821-7777
www.Mobility-More.com

CRITERIA FOR A MANUAL WHEELCHAIR

Patient: _____DOB:_____

Patient's mobility limitation impairs ability to participate in **ONE** or more activities such as toileting, feeding, dressing, grooming, and bathing.

AND

1.) Mobility limitation cannot be resolved by use of cane or walker **AND**

2.) Patient is able to safely use a manual wheelchair **AND**

3.) Patient's functional mobility deficit can be resolved by the use of a manual wheelchair.

4.) If patient has had a weight gain, please state in medical notes.

Please send us the clinical notes documenting all of the above criteria. If you have any questions, please contact us at 704-821-7777.

I, UNDERSTAND, AND CERTIFY THE ABOVE PRESCRIBED DURABLE MEDICAL EQUIPMENT AND SUPPLIES ARE MEDICALLY NECESSARY FOR THIS PATIENT IN ORDER FOR THIS PATIENT TO PERFORM ACTIVITIES OF DAILY LIVING.

Doctor's Signature	**NPI Number**	**Date**

Fax To: 704-821-7777