Standard(Manual) Wheelchair Request Form

Handi Customer Number _____ Date _____

Patient Information:

Customer's Name: _____ Start Date: _____

Ordered by: _____ Phone #: _____

Customer's Height: _____ Customer's Weight: _____

Diagnosis: _____ Date Chair Needed: _____

Length of Need (Months): _____ 1-99 (99 = Lifetime)

1. Hours per day customer will be in the chair: _____ hours per day
2. Will the wheelchair be used within the home? ☐ Yes ☐ No
3. Can he/she self propel the chair using their feet or arms? ☐ Yes ☐ No
4. Is there a history of skin breakdown? ☐ Yes ☐ No

   If yes, please provide a description and the locations:

_____

_____

5. Is the patient currently receiving any type of advanced wound healing therapy? ☐ Yes ☐ No

   If yes, what type? _____

****NOTE: All Handi Medical Supply standard wheelchairs come equipped with:****
****seatbelt, anti-tippers, and adjustable arms****

SIZES (width of wheelchair): 10" ☐ 12" ☐ 14" ☐ 16" ☐ 18" ☐ 20" ☐ 22" ☐ 24" ☐

Leg Rests: ☐ Standard ☐ Elevating

Reclining Back: ☐ Yes ☐ No

Is there a need for a seat cushion: ☐ Yes ☐ No

If yes, please check option:

☐ Comfort Company 2" Elements Cushion (non-contoured cushion with gel and foam)

☐ Comfort Company Curve Cushion (high-density foam, contoured cushion)

Is there a need for a supportive back cushion? ☐ Yes ☐ No

If yes, please check option:

☐ Comfort Company Viscoback (Visco memory foam contours to the user's body)

☐ Comfort Company Elements back (tension adjustable fabric w/1" foam)

Other options or instructions: _____

Does the patient's medical needs require a wheelchair other than the standard manual? ☐ Yes ☐ No

If yes, a Rehab Specialist will provide an assessment to determine the need for a specialized wheelchair.

Please return the following:

This form
The patient's demographic information
The patient's insurance information

Fax Back: **866-388-5430** **www.handimedical.com**

Tel: 651-644-9770 or 800-514-9979 2505 University Avenue West, St. Paul, MN 55114

Standard(Manual) Wheelchair Request Form

Handi Customer Number

Patient Information:

Name: _____ Height: _____

DOB: _____ Weight: _____

Diagnosis: _____ Equipment Prescribed: _____

Please check your answers below: DNA - Does Not Apply

1.	☐ Yes	☐ No	☐ DNA	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 (MRADLs) such as toileting, feeding, dressing, grooming, and bathing in customary locations in the home?
2.	☐ Yes	☐ No	☐ DNA	Can the patient's mobility limitations be sufficiently resolved by the use of an appropriately fitted cane or walker?
3.	☐ Yes	☐ No	☐ DNA	The beneficiary's home provides adequate access between rooms, maneuvering space, and surfaces for use of the manual wheelchair that is provided.
4.	☐ Yes	☐ No	☐ DNA	Will the use of a manual wheelchair significantly improve the patient's ability to participate in MRADLs and the patient will use it on a regular basis in the home?
5.	☐ Yes	☐ No	☐ DNA	Has the patient expressed a willingness to use the manual wheelchair in the home?
6.	☐ Yes	☐ No	☐ DNA	Does the patient have sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair that is ordered in the home during a typical day?
7.	☐ Yes	☐ No	☐ DNA	Does the patient have a caregiver who is available, willing, and able to provide assistance with the wheelchair?
8.	☐ Yes	☐ No	☐ DNA	If a standard hem-wheelchair (K0002) is ordered does the patient require a lower seat height because of short stature or to enable the patient to place his/her feet on the ground for propulsion?
9.	☐ Yes	☐ No	☐ DNA	If a lightweight wheelchair (K0003) is ordered is the patient unable to self-propel in a standard weight wheelchair and would be able to self-propel in a lightweight wheelchair?
10.	☐ Yes	☐ No	☐ DNA	If a high strength lightweight wheelchair (K0004) is ordered does the patient need this type of wheelchair for one of the following reasons:
10a.	☐ Yes	☐ No	☐ DNA	The patient self-propels the wheelchair while engaging in frequent activities in the home that cannot be performed in a standard or lightweight wheelchair.
10b.	☐ Yes	☐ No	☐ DNA	The patient requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair, and spends at least two hours/day in wheelchair.

Check all that apply:

- ☐ Height Adjustable Arms (E0973) - Patient requires height that is different than available using nonadjustable arms and will be using for more than 2 hours per day.
- ☐ Anti-Tippers (E0971) - patient is able to self propel and is needed to prevent tipping on ramps.
- ☐ Seatbelt (E0978) - Patient has upper body weakness or instability and requires belt to maintain proper positioning and safety.
- ☐ Elevating Leg Rests (K0195) - Patient has condition or brace that prevents 90 degree flexion or edema of lower extremities

Estimated Length of Need (Months): _____ 1-99 (99 = Lifetime)

PLEASE SIGN AND DATE BELOW, AND RETURN FORM WITH SUPPORTING MEDICAL RECORDS:

Physician/NP/PA/Medical Practitioner Signature	Clinic Name / Location	Date
Please print name	Please print Clinic	Phone
NPI number		

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