HANDI medical

Walker Request Form

Handi Customer Number _____

Patient Information

Name: _____ Start Date: _____

DOB: _____ Height: _____

Diagnosis: _____ Weight: _____

Please check the box of the equipment being ordered

- ☐ Standard Walker without seat with wheels (E0143)
- ☐ Standard Bariatric Walker (if client weighs over 300 lbs) with wheels (E0149)
- ☐ 4-Wheeled Walker with Seat, Brakes (E0143, E0156, E0159)
- ☐ Bariatric Walker with Seat, Brakes (if client weighs over 300 lbs) (E0149, E0156, E0159)

Please check answer below:

☐ Yes ☐ No Does your patient have a mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADL ex: toileting, feeding, dressing, grooming, etc.) that he/she would otherwise not be able to do safely?

☐ Yes ☐ No Will the walker be used within the home?

☐ Yes ☐ No Can the mobility deficit be sufficiently resolved with the use of a Walker?

☐ Yes ☐ No Is patient able to safely use the ordered equipment?

Please explain: _____

_____

☐ Yes ☐ No Has the patient had similar equipment in the past?

If yes, how old is the equipment? _____

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

Case Manager (if applicable) | Case Manager Organization | Phone

Fax Back: 866-388-5430

Phone: 651-644-9770 Fax: 651-644-0602

2505 University Avenue West, St. Paul, MN 55114