

PT/ OT PRESCRIPTION

PHYSICIAN'S INFORMATION

NAME:

ADDRESS:

PHONE:

FAX:

PATIENT INFORMATION

NAME:

ADDRESS:

PHONE:

DESCRIPTION OF REQUESTED DME:

PT/OT Wheelchair Seating Evaluation

DX:

Notes:

BY SIGNING BELOW, I AUTHORIZE the use of this document as a legal prescription, and I certify that the above prescribed equipment is medically necessary and reasonable, and is not being purchased for convenience. I will maintain an original signed copy of this order in my medical records and make it available to Medicare, their authorized agents or other insurer, if required.

X _____

Physician's Signature

Date