



# 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 \_\_\_\_\_

## 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 \_\_\_\_\_