



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 _____ Therapist Email _____

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 _____