DETAILED WRITTEN ORDER

Patient Lift

Patient Name: ______________________	Physician Name: ______________________
Address: ______________________	Address: ______________________
Phone: __________ DOB: _______ M ☐ / F ☐	Phone: ______________ NPI ____________

Patient Medical Records: Medicare (insurance company) requires ***ALL*** of the following coverage criteria to be listed in Patient Medical Records. All clinical notes must be signed by physician.
1. The patient lift is required to transfer the patient between bed and a chair, wheelchair, or commode; ***AND***
2. Without the use of a lift, the patient would be bed-confined; ***AND***
3. A caregiver is available and capable to operate the lift.

***When **ALL** the criteria above are MET and documented in patient's clinical notes after evaluation, then please proceed to confirm the following Detailed Written Order (DWO).*

EST LENGTH OF NEED (# OF MONTHS): ________ **1-99 *(99=LIFETIME)***	**DIAGNOSIS CODE(S) (ICD-10):** __________, __________, __________, __________, __________	Ht:________(in) Wt:_______(lbs)
Equipment Ordered: *Please ☑ select one (1)*		

☐	Patient Lift (E0630)	Hydraulic or Mechanical, includes any Seat, Sling, Strap(s) or Pad(s)
		Sling Type: ☐ With Commode Cutout ☐ Without Commode Cutout

Physician Signature: ______________________________________ Order Date: ______________

(SIGNATURE STAMP & DATE STAMP ARE NOT ACCEPTABLE)

Starting Date for patient to use equipment if different from Order Date: ____________________

Please **FAX** to **(646) 736-5423** Confucius Pharmacy & Surgical Supplies.

Any question, please feel free to call _______________ at ____________________ext. _____

We must have both copy of **the face-to-face medical record** and the completed DWO on file that shows your own evaluation why patient needs the prescribed item(s).