Patient's Name_____

Patient's Address_____

Patient's Home Phone_____ Patient's Cell Phone_____

Patient's Date of Birth_____ Weight_____ Height_____

DIAGNOSIS (ICD 10 codes)

_____ _____ _____ _____

Start Date_____ **Length of Need**_____

EQUIPMENT

☐ CANE ____Standard ____Quad

☐ WALKER ____ with Wheels (5" fixed wheels are standard)

☐ WALKER WITH WHEELS, SEAT and BRAKES (Rollator) Color Preference_____

☐ MANUAL STANDARD WHEELCHAIR

____ Lightweight ____ Heavy Duty

____ Elevating Leg Rests ____ General Use Back Rest ____ Brake Extensions

____ General Use Cushion ____ Anti-tippers

☐ TRANSPORT CHAIR

☐ POWER WHEELCHAIR EVALUATION (conducted by an ATP in the patient's home)

☐ SEMI-ELECTRIC HOSPITAL BED ____1/2 Rails ____ Full Rails ____Trapeze Bar ____APP Pump/Pad ____Gel Pad

Other (please specify) _____

☐ BEDSIDE COMMODE

Please attach signed Face-to Face Office Visit Notes
(Notes from the patient's office visit must be within six (6) months of the prescription date and should document need and physician's assessment—with physician's signature and date)

Please attach Insurance information

Practitioner's Name(please print or stamp)_____

Address_____

Telephone_____Facsimile_____

NPI#_____Physician's Signature and Date:_____

1900 Apperson Drive, Salem – (540) 380-3383 – Fax (540) 380-3393
For Questions 24/7/365 Call (540) 380-5588
479 Piney Forest Road, Danville – 434) 797-2332 – Fax (434) 793-3916

Please fax this form (or a prescription/order) with this information, and supporting documents to:

Commonwealth Home Health Care, Inc.
479 Piney Forest Road
Danville, Virginia 24540
(434) 797-2332
FAX (434) 793-3916

Please contact us with any questions you may have about medical equipment referrals.