



Wheelchair & Accessories Referral Form

(This is a form to initiate a referral. Additional documentation may be required depending on insurance or product.
If needed, we will notify your office via phone or fax.)

Please note in your patient's medical record why product is required.

Patient Name:		Phone:
Height:	Weight:	DOB:
Address:		
City:	State:	Zip:
Primary Insurance:		Policy No.:
Secondary Insurance:		Policy No.:
Physician/Provider Name:		License No.:
Phone:		
Diagnosis:		
Anti-Tippers: (for patient safety) <input type="checkbox"/> Front <input type="checkbox"/> Rear Arm Assemblies: <input type="checkbox"/> Desk Length <input type="checkbox"/> Full Length <input type="checkbox"/> Full Length Height Adjustable Cushion: (for patient comfort) <input type="checkbox"/> Curve Cushion (3 inch height) <input type="checkbox"/> Back Cushion <input type="checkbox"/> Other: _____ Front Riggings: <input type="checkbox"/> Articulating leg rest <input type="checkbox"/> Elevating leg rest <input type="checkbox"/> Swing-a-Way leg rest <input type="checkbox"/> Gerber Device <input type="radio"/> Left Side <input type="radio"/> Right Side		Seat Belt (auto style): (for patient safety) <input type="checkbox"/> 48 inch <input type="checkbox"/> 60 inch Seat to Floor Height: <input type="checkbox"/> Maximum (19 inches) <input type="checkbox"/> Minimum (17 inches)/Hemi Position Wheel locks: <input type="checkbox"/> Push to Lock (standard) <input type="checkbox"/> Pull to Lock <input type="checkbox"/> Push to lock-Hill Holders (anti-roll back device) <input type="checkbox"/> Wheel Lock Extension (6 inch length) <input type="checkbox"/> Oxygen tank holder <input type="checkbox"/> IV Holder

Physician Signature _____ Date _____

Erie, PA:	1700 Peach Street	(814) 877-6121	Fax: (814) 455-9440
Bradford, PA:	600 Chestnut Street	(814) 362-8141	Fax: (814) 362-9113
Meadville, PA:	303 Chestnut Street	(814) 337-6900	Fax: (814) 337-6902
Jamestown, NY:	512 West Third Street	(716) 664-5092	Fax: (716) 664-6570