State of Illinois
Department of Healthcare and Family Services

Standard Manual Wheelchair Questionnaire

Participant's Name Elisa Cecil RIN 104444690 Birth Date 08/12/1974

Height 5'9" Weight 208 LB Participant's Hip Width 18"

Procedure code and description of wheelchair
K0003 - LIghtweight Manual wheelchair

Weight capacity of wheelchair 300 LB Width of wheelchair 18"

Diagnosis

Current ambulation status

Upper body control and strength

Does participant have the ability to self propel? Yes ☐ No ☐

If not, why?

If the participant is unable to safely self-propel the manual wheelchair does he/she have a caregiver who is available, willing, and able to provide assistance with the wheelchair? Yes ☐ No ☐

Does the participant need wheelchair to meet activities of daily living over the use of a walker or cane? Yes ☐ No ☐

If not, why?

Is this being requested for temporary use for injury or post op? Yes ☐ No ☐

If yes, date of injury or surgery _____ Expected duration of need _____

*All requests for renewal of post surgical/post injury wheelchairs will require updated MD script along with copy of MD clinical follow-up progress note.

Will this manual wheelchair meet participant's long term needs (3-5 years) or will participant need a customized wheelchair?

Physician's Name _____ Telephone Number _____

Attending Physician's Signature _____ Date Signed

HFS 3701L (N-8-13)

Advanced Medical Supply
3322 N. Milwaukee Avenue, Chicago, IL 60641
Phone: (773) 205-6993 Fax: (773) 205-6994

DETAILED WRITTEN ORDER

Patient's Name:	Elisa Cecil	
Address:	308 Walnut St Knoxville, Il 61448	
Phone:	309-337-0878	
DOB:	08/12/1974	
Insurance Name and ID.	Medicare:	Medicaid: 104444690
Other Insurance Name and ID :		

R x	PRODUCT DESCRIPTION	QUANTITY
	Manual wheelchair with swing away footrests, safety belt, adjustable arm rest, heel holder-loops and anti-tippers.	1
	General use wheelchair seat cushion.	1
	General use wheelchair back cushion.	1
	Shower chair with back	

Height: 5'9'' Weight: 208 LB

LENGTH OF NEED (# OF MONTHS): 99=LIFETIME

DIAGNOSES:

[ ] Alzheimer's disease	[ ] Dementia	[ ] Pendulous Abdomen
[ ] Amputation of_____	[ ] Dizziness	[ ] Loss of Appetite
[ ] Unsteady gait	[ ] Emphysema/COPD/Asthma	[ ] Loss of Weight
[ ] Bronchial Asthma	[ ] Fracture of_____	[ ] Renal Failure
[ ] Dysphagia	[ ] Generalized Body Weakness	[ ] S/P CVA/Hemiparesis
[ ] Malnutrition	[ ] Hernia (inguinal) (umbilical) (ventral)	[ ] Carpal Tunnel Syndrome
[ ] Chronic Incontinence [ ] Urine [ ] Stool	[ ] Organic Brain Syndrome	[ ] S/P Open Heart Surgery
[ ] CVA	[ ] Osteoporosis_____	[ ] Debility
[ ] CHF	[ ] Paralysis	[ ] Spondylosis (cervical) (lumbar)
[ ] Degenerative Osteoarthritis of_____	[ ] Parkinson's disease	[ ] Sprain/Strain of_____
[ ] Diabetes Mellitus	[ ] Varicose Veins/ Venous Insufficiency	[ ] HTN

I, the undersigned, certify that the above prescribed supplies/equipment are medically necessary for this patient's well being. In my opinion, the supplies are both reasonable and necessary to the accepted standards of medical practice in treatment of this Patient's condition and are not prescribed as convenience supplies. By signing this form, I am confirming that the above information is accurate.

DOCTOR'S INFORMATION

Doctor's Signature: _____ Date:_____
Print Name: _____ NPI#: _____
Facility Name: _____
Address _____
Phone: _____ Fax: _____