



Admissions Office
816-751-7783 (Ph)
816-751-7984 (Fax)

WHEELCHAIR CLINIC PRESCRIPTION

ATTENTION: CORF Medicare Regulations require that ALL sections of this form be completed.

Patient Name: _____ DOB: _____

Phone: _____ Age: _____

Primary Diagnosis: _____

Therapy Needs/Rehab Diagnoses:

- L Hemi R Hemi Paraplegia Paraparesis Quadriplegia Quadriparesis
- Spasticity Neglect Coordination Other: _____

Wheelchair & Seating Evaluation

Details: _____

Precautions/Contraindications: (Must mark at least one)

- None Seizure Weight bearing: _____ ROM _____ Other: _____

Frequency: 1 time for **Duration:** until eval is complete

Certification: As referring physician, I certify that the therapy services ordered in this prescription/plan of care are medically necessary and reasonable under CORF Medicare guidelines. I further certify that the patient is under my care and that these services are furnished under my plan of care as required by Medicare regulations. All services are to be provided by qualified personnel as defined by Medicare program standards.

Physician's Name: _____ NPI# _____

Physician Signature (MD or DO ONLY*) _____ Date: _____

**Only MD's or DO's can sign therapy orders per Medicare CORF regulations. NPs and PA's cannot sign CORF orders.*