SAMPLE PHYSICIAN ORDER FOR WHEELCHAIR OR ADAPTED STROLLER AND SEATING EVALUATION

Physician Order

Date:

Patient Name:
Date of Birth:
Home Phone:

Order(s):
1) Therapist/seating specialist evaluation for mobility needs for mobility for:
(List intended uses for device here, such as :)
   • Distances
   • Family excursions
   • School and community participation
   • Safety
   • Endurance
   • Other ______

2) Manual custom wheelchair or adaptive stroller
   (Provider can specify which, or let the therapist work with the family to decide)

Clinical Diagnosis/History:
   • List patient’s relevant diagnoses here
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   •
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Provider’s signature

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PROVIDER, MD
Provider’s contact information