PETERSEN MEDICAL
BREATHE EASIER
Utah • Idaho • Southern Colorado
Phone: 801-373-1010 Fax: 801-373-2217

MOBILITY REFERRAL

Patient Name: ______________________ Phone: __________

Address: __________ City: __________ State: ______ Zip: ______

Primary Insurance: ______________________ ID#: __________

Secondary Insurance: ______________________ ID#: __________

Height: __________ Weight: __________ DOB: __________

** **Please include copy of insurance card(s) and chart notes from most recent visit.**

☐ **PT/OT THERAPY EVALUATION** (Therapist will visit patient's home to evaluate equipment needed for MRADL's)

POWER MOBILITY

☐ Complex Rehab Wheelchair
☐ Motorized Wheelchair
☐ Motorized Scooter

MANUAL WHEELCHAIRS

☐ Standard
☐ Ultra Light Weight WC
☐ Tilt in Space WC

OPTIONS

☐ Adjustable Height Armrests
☐ Elevating Leg Rests
☐ Oxygen Tank Holder
☐ Brake Extensions
☐ Headrest
☐ Anti-Tippers

Other: ______________________________

SEAT CUSHIONS

☐ General Use
☐ Skin Protections
☐ Positioning
☐ Position & Skin Protection

BACK CUSHIONS

☐ General Use
☐ Skin Protection
☐ Positioning
☐ Position & Skin Protection

Other: ______________________________

Print Physician's Name: ______________________ Length of Need (99): __________

Physician's Signature: ______________________ Date: __________

NPI #: ______________________ Phone #: __________

Orders Sent By: ______________________

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