ALL·STAR MEDICAL

Walker Request Form

Patient Information

Name: ______ Start Date: ______

DOB: ______ Height: ______

Diagnosis: ______ Weight: ______

Please check the box of the equipment being ordered

- ☐ Standard Walker without seat with wheels (E0143)
- ☐ Standard Bariatric Walker (if client weighs over 300 lbs) with wheels (E0149)
- ☐ 4-Wheeled Walker with Seat (E0143, E0156)
- ☐ Bariatric Walker with Seat (if client weighs over 300 lbs) (E0149, E0156)

Please check answer below:

☐ Yes ☐ No Will the use of the above listed piece of equipment enable your patient to safely participate in one or more mobility-related activity of daily living (ex: toileting, feeding, dressing, grooming, etc.) that he/she would otherwise not be able to do?

☐ Yes ☐ No Can the mobility deficit be sufficiently resolved with the use of a Cane/Crutch?

☐ Yes ☐ No Can the mobility deficit be sufficiently resolved with the use of a Walker?

☐ Yes ☐ No Is patient able to safely use the ordered equipment?

Please explain: ______

☐ Yes ☐ No Has the patient had similar equipment in the past?

If yes, how old is the equipment? ______

Estimated Length of Need (Months): ______ 1-99 (99 = Lifetime)

PLEASE SIGN AND DATE BELOW, AND RETURN FORM WITH SUPPORTING MEDICAL RECORDS:

Physician/NP/PA/Medical Practitioner Signature	Clinic Name / Location	Date
Please print name	Please print Clinic	Phone
NPI number		