FISHER | TITUS
fishertitus.org
272 Benedict Avenue
Norwalk, OH 44857
419-668-8101 • 800-589-3862

WHEELCHAIR INTAKE FORM

Patient name: _____

Date of Birth: _____

Patient Contact Number: _____

Contact Person (if different than patient):_____

Contact Person's Number: _____

Primary Insurance and Policy Number: _____

Secondary Insurance and Policy Number: _____

If you have Medicaid, provide ID number: _____

If you have BCMH, provide ID number: _____

Prescribing Doctor: _____

Reason for this wheelchair referral: (ex. my current one is old and I have outgrown it, I suffered a stroke and can no longer walk)

_____

_____

Is there a Durable Medical Equipment (DME) provider that you prefer? (ex. NPL home Medical, National Seating & Mobility, A&A medical, Kaiser Wells etc.)

_____

PLEASE MAKE SURE THAT YOUR PREFERRED PROVIDER IS INCLUDED IN YOUR INSURANCE PLAN.

Office use only:
Appointment date and time_____
_____Copy of page 1 intake given to therapist with appointment time
_____ Paper work mailed

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_____ Paper work returned
_____DME provider contacted DME company_____
Provider name_____
Contact number_____ able to come? Y or N

Welcome _____ to Fisher Titus Medical Center's Rehabilitation Department!

We are excited to help you with your WHEELCHAIR and/ or POWER MOBLITY needs!

You are scheduled for an appointment with_____

on_____ at _____.

Please complete the following paperwork and bring on the day of your appointment. Failure to complete this paperwork may result in rescheduling of your appointment or a delay in getting your equipment.

PLEASE MAKE SURE THAT YOUR PREFERRED DURABLE MEDICAL EQUIPMENT (DME) PROVIDER IS INCLUDED IN YOUR INSURANCE PLAN. WE WILL ASSIST YOU IN FINDING A DME PROVIDER IF YOU DO NOT HAVE A PREFERENCE, BUT IT IS ULTIMATELY THE PATIENT'S/ CAREGIVER'S RESPONSIBILTY TO VERIFY WHICH DME PROVIDERS ARE ON YOUR INSURANCE PLAN.

Please bring the doctor's prescription and insurance cards with you.

We look forward to serving you and meeting your needs!

Please contact the Rehabilitation Dept. at 419-660-2700 with any questions.

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THANK YOU!

Please give us your medical history and list all your diagnosed medical conditions: (ex: amputee, hemiplegic, COPD, cerebral palsy, scoliosis etc.).

_____

_____

_____

_____

_____

_____

Please list the 3 most important reasons why you would like a wheelchair, how it would benefit you during your day, and how it would improve your quality of life.

1) _____

_____

_____

2) _____

_____

_____

3) _____

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_____

_____

For each item below please describe your limitations. If you do not have limitations or concerns with the item, please write N/A.

1) Sitting posture/balance_____
2) Standing posture/ balance_____
3) Motion and strength at my hips_____

   _____
4) Motion and strength at my knees_____

   _____
5) Motion and strength at my ankles/feet_____

   _____
6) Motion and strength of my back and abdominal area_____

   _____
7) Motion and strength of shoulders_____

   _____
8) Motion and strength of elbows_____

   _____
9) Motion and strength of wrist/ hands_____

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_____

10) Muscle Tone (high tone/ low tone/ normal)_____

_____

11) Skin condition/ skin integrity/ prior ulcers or skin breakdown_____

_____

12) Sensation (ability to feel normal sensations, touch, pressure, pain etc.) _____

_____

13) Are you able to shift your body weight to relieve pressure on your buttock?

_____

14) Bowel and bladder function (continence) _____

_____

15) How do you get in and out of bed?_____

_____

16) How do you get in and out of a chair?_____

_____

17) Do you have any ability to walk?_____

_____

18) Do you ever get short of breath?_____

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_____

19) Do you have pain anywhere?_____

_____

20) Other strengths or limitations?_____

_____

Please complete the following questions:

How many hours of the day are you in your wheelchair? _____

How will you transport a wheelchair? _____

_____

Do you have a ramp to get in and out of your home? _____

_____

Is your home wheelchair accessible, including kitchen, bathroom, and

bedroom? _____

_____

_____

_____

Describe your support system (all the people who help you if needed):

_____

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_____

_____

Is there anything else the therapist should know about you and your need for a wheelchair?_____
_

Do you currently have a wheelchair?: YES/ NO

If YES, please complete the following questions. If NO, you are finished with the questionnaire. Thank you!

What is the Manufacturer of your current chair? (ex: Invacare)

_____

What is the maker of your current chair? (ex: Solara 3G)

_____

What is the serial number? (it can be found on a metal plate on the chair, ex: 12GE003746)_____

Please tell us what features you *LIKE* or *DISLIKE*. Write N/A if not a feature of your current chair.

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Weight of the chair_____

Wheels_____

Distance of the seat to the ground_____

Seat cushion_____

Seat back cushion_____

Width of the seat_____

Depth of the seat_____

Leg rests_____

Footrests_____

Arm rests_____

Head support_____

Lateral/ Side/ Trunk support_____

Brakes_____

Recline feature_____

Tilt feature_____

Base elevation_____

Power controls_____

Portablity_____

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Are there any other features that you *LIKE* or *DISLIKE* about your current chair?

_____

_____

Any features on a wish list for us to consider when ordering your new chair?

_____

_____

Which DME provider supplied the chair? And are you happy with the maintenance service? _____

_____