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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Provider's signature

PROVIDER, MD
Provider's contact information