Aspire Mobility
611 Park Meadow Rd. Ste. B
Westerville OH 43081

Office: (614) 392-0394
Fax: (614) 437-9538

Standard Written Order (SWO)

Physician Information

Name:

Address:

Phone:

Fax:

Patient Information

Name:

Height:

Weight:

Description of Requested DME (Check all Appropriate Boxes)

Please also send Patient's demographic sheet along with this order.

☐ Custom Manual Wheelchair
☐ Custom Power Wheelchair
☐ Wheelchair Seating & Positioning

DX:

Length of Need:

# of Months: _____
(99 = Lifetime)

Rx: ☑ Physical/Occupational Therapist to evaluate for mobility needs

These devices require either a PT/OT evaluation from someone who does not have a financial relationship with Aspire Mobility as well as a Face-to-Face Mobility Evaluation by a MD.

Notes:

By signing below, I authorize the use of this document as a legal prescription, and I certify that the above prescribed equipment is medically necessary and reasonable, and is not being purchased for convenience. I will maintain an original signed copy of this order in my medical records and make it available to Medicare, their authorized agents or other insurers, if required.

NPI #:

Physician's Printed Name Physician's Signature Date