Physical Therapy / Occupational Therapy Evaluation

Written Order

1. Patient Name: _____

2. Description: PT / OT Evaluation for Power Mobility Device

3. Patient Diagnosis:

ICD-10 CODE	DIAGNOSIS
____ . ____	_____
____ . ____	_____
____ . ____	_____
____ . ____	_____
____ . ____	_____

4. Physician's Signature: _____

No Signature Stamps.

_____

Physician Printed Name.

5. Date: _____

Please fax back to Clinical Documentation Dept., Hoveround at (800) 455-8556