NORTHEAST MEDICAL PRODUCTS, INC
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PATIENT LIFT ORDER FORM

Patient _____ DOB _____

Address _____

Diagnosis Codes _____ Length of Need_____

Height _____ Weight_____

Equipment Ordered:

_____ E0630 Patient lift, hydraulic or mechanical, includes any seat, sling, straps or pads

Style of sling preferred _____

Coverage Questions:

Y N Does the patient need the lift in order to be transferred between bed and a chair, wheelchair, or commode?

Y N Without the use of a lift, would the patient be bed confined?

Y N Is there a caregiver in the house who can oversee and assist with transfers?

Physician Name _____

Address _____

Phone _____ Fax _____

NPI _____

Physician Signature Date