

# Power Mobility Device (PMD) Prescription

Patient's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Face-to-Face Examination Date: \_\_\_\_\_

Description of item that is ordered.

(Power Mobility or if known state Power Wheelchair or Power Scooter):

\_\_\_\_\_

Pertinent diagnosis/conditions relating to the need for Power Mobility:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Length of Need: \_\_\_\_\_ Lifetime \_\_\_\_\_ Months

Physician's Name: \_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Date of Physician's Signature: \_\_\_\_\_

Physician's Fax Number : \_\_\_\_\_