



Fax: 216-332-1555  
Phone: 877-304-4684

### Equipment Order Form

Facility: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date Equip Needed: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Discharge Date: \_\_\_\_\_

Deliver Equip To: \_\_\_\_ Therapy Dept. \_\_\_\_ Patient's Rm \_\_\_\_ Home Address

**(Please indicate if you would like a phone call verifying receipt of this fax:  Yes  No)**

**Lightweight Wheelchair**

Seat Width - 16, 18, 20, 22

Seat Depth - 16, 18

Arms – Full / Desk Fixed / Adjustable

Leg Rests – Elevating or Footrests

Wheel Lock Extensions  Yes  No

Seat Belt  Yes  No

Anti Tippers  Yes  No

Seat Cushion  Yes  No General Use Back Cushion  Yes  No

**Commode**

3 in 1

Heavy Duty

Drop Arm

**Tub Transfer Bench**  **Tub Seat with Back**  **Tub Seat w/o Back**

**Semi Electric Hospital Bed** – Full Rails / Half Rails  **Nebulizer**

**O2** – Liter Flow \_\_\_\_\_ Duration \_\_\_\_\_ PO2 /SAT \_\_\_\_\_ Test Date \_\_\_\_\_

**Walker**  5 inch wheels  3 inch wheels  fixed  swivel

Other \_\_\_\_\_

Please fax a face sheet along with your order including insurance information and diagnosis.  
Fax (216)332-1555

