State of Illinois
Department of Healthcare and Family Services

Power Mobility Devices and Custom Manual Wheelchairs
PHYSICIAN'S FORM

(Physician Also To Sign PT/OT Evaluation / Order Form 3701H Information Must be Complete & Legible)

Patient's Name _____ RIN _____ Birth Date _____

Physician's Name (Print) _____ State License No. _____

Physician's Phone Number _____ Face-to-Face Evaluation Date _____

The Patient Needs: ☐ Power Wheelchair ☐ Power Scooter ☐ Custom Manual Wheelchair

Duration of Need (Months) _____ (99 = Lifetime)

Medical Necessity Must Be Documented For Each Item Ordered On Form 3701H (Brief Narrative Description)

☐ **Check if Delegated To Evaluating Physiatrist or Physical/Occupational Therapist - If not delegated, provide separately.**

Patient's Diagnosis: -Date Onset, if known

Describe Patient's Disabilities That Require Mobility Equipment:

Neuro/Musculo/Skeletal

Date Onset _____ ☐ Slowly Progressive ☐ Rapidly Progressive ☐ Stable

Cardiovascular/Pulmonary

Date Onset _____ ☐ Slowly Progressive ☐ Rapidly Progressive ☐ Stable

Weakness (State Etiology)

Date Onset _____ ☐ Slowly Progressive ☐ Rapidly Progressive ☐ Stable

Other

Date Onset _____ ☐ Slowly Progressive ☐ Rapidly Progressive ☐ Stable

Patient's Potential For Improvement: ☐ None Expected ☐ Good Expected in (Months) _____

Has Patient Had Surgery Recently Or Is It Being Planned? No ☐ Yes ☐

If yes, what and when? _____

What Is Expected Effect Of Surgery On Patient's Mobility & When Is Improvement Expected:

Patient's Current Weight (lbs) _____ Weight 1 year ago (lbs) _____ Weight 2 years ago (lbs) _____

Describe Growth Of Pediatric Patient Past 2- 5 Years - (Height & Weight)

The Patient Can Operate The Ordered Equipment Safely & Responsibly Yes ☐ No ☐

Patient Is Restricted To Operating In Home Environment Only Yes ☐ No ☐

Comment: _____

If A Power Wheelchair Is Ordered, Could A Power Scooter Serve The Patient's Needs? If Not, Why?

I the undersigned certify that the above information is true, that this patient requires the ordered equipment/accessories because of his/her documented medical condition(s), and that the use of the equipment is not for the patient's convenience but is medically necessary for mobility.

I also certify with my signature that I have reviewed all information provided by the evaluating Physiatrist / Physical/Occupational Therapist and CRTS and concur with the recommendations/order documented on HFS Form 3701H.

_____ _____

Ordering Physician's Signature Date

FAX COMPLETED FORM TO 888-518-7568