FOOT COMFORT CENTER

9808 BUSTLETON AVENUE, PHILADELPHIA, PA 19115
PHONE (215) 676-7463
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CERTIFICATE OF MEDICAL NECESSITY FOR CANES, WALKERS, AND COMMODES

Patient Name _____ **SS#** _____

Patient Address _____ **DOB** _____

Phone Number _____ **Patient Height** _____ **Patient Weight** _____

Insurance(s) _____ **Length of Need (# of months, 99= lifetime)** _____

Diagnosis (include ICD-9 code) _____

☐ **Folding Walker** ☐ **with Wheels** ☐ **with Seat and Braking System**
☐ **Straight Cane** ☐ **Quad Cane**
☐ **Heavy Duty Folding Walker (patient weighs more than 300lbs)**

Does the patient have the mobility limitation that significantly impairs his/her ability to participate in one or more mobility-related activities of daily living (MRADL) in the home?
_____ ☐ **YES** ☐ **NO**

Can the patient use the equipment?
_____ ☐ **YES** ☐ **NO**

Can the functional mobility deficit be sufficiently resolved with the use of this equipment?
_____ ☐ **YES** ☐ **NO**

☐ **Bedside Commode** ☐ **Heavy Duty Bedside Commode (patient weighs more than 300lbs.)**

Is the patient room confined?
_____ ☐ **YES** ☐ **NO**

Is the patient confined to a floor of the home where there is no bathroom?
_____ ☐ **YES** ☐ **NO**

_____ _____ _____
PHYSICIAN / NURSE PRACTITIONER HANDWRITTEN SIGNATURE | DATE | EFFECTIVE DATE (IF DIFFERENT FROM SIGNATURE DATE)

_____ _____
PHYSICIAN / NURSE PRACTITIONER NAME (TYPED OR PRINTED) | PHONE NUMBER