Clinician: _____

Patient Name: _____ **DOB** _____

Date of Face to Face Assessment: _____

Fax back to: 317-516-0166

Rx

- ☐ **Group 3-Air Fluidized Therapy Bed (Sand Bed)**
- ☐ **Hydraulic Patient Lift**
- ☐ **Trapeze Bar**

ICD-10 Codes: _____ _____ _____

Length of Need : _____

Signature _____

Order Date _____