Print Form

CalOptima Health

Clinical Questionnaire:
Referring Physician Authorization for New Wheelchair and/or Custom Seating Equipment

Patient Name: Medi-Cal Number (CIN):

Thank you for taking the time to answer the following questions about your patient's need for new seating equipment. Your complete answers will ensure that your patient's authorization can be reviewed in a timely manner.

1. Please describe the patient's diagnosis and nature of injury:

2. Give a brief explanation of the patient's prognosis:

3. What is the patient's current functional status?

4. If you are prescribing a custom manual or power wheelchair, please give a brief explanation of why a standard manual wheelchair is not adequate for the patient's use:

5. If a power wheelchair is being requested, what is patient's current cognitive status?

   ☐ Not Alert ☐ Alert *Oriented to*: ☐ *Self* ☐ *Other* ☐ *Place* ☐ *Time*

6. If the patient is being evaluated for a custom seating system or therapeutic cushion, please explain why this is being requested.

7. Does the patient have a history of any skin breakdown? ☐ Yes ☐ No

8. List all the patient's relevant previous or pending surgeries:

9. If a new wheelchair, seating system or therapeutic cushion is being prescribed to replace existing equipment, please explain why the current equipment no longer meets the patient's needs.

10. What medical and functional objectives will be met with the equipment you have prescribed?

Additional relevant information:

Physician's Signature: _____ Date: _____

Please complete and return this form to:
CalOptima Health UM Dept · P. O. Box 11033 · Orange, CA 92856 · Phone: (714) 246-8686 · FAX: (714) 481-6516