Adult Care Facilities Medical Equipment Waiver Addendum

Physician Nam	e:	
NYS License No	o.:	
Addres	ss:	
Phon	e:	
Fa	x:	
Email Addres	ss:	
Patient Nam	۵۰	
Date of Birt		
T b - b - l		
The below re	quest na	s been deemed medically necessary for the above-named patient and is not to be used as a restraint.
		ORDERS (Limit 1 per patient)
		Hospital Bed 1/2 Side Rail □ Yes □ No
		Enabling Device Specific Type:
		Trapeze
		Other Specify:
Physician Signatu	re	
Date		