Mobility Aid Prescription

Patient Name: [Patient's Full Name]

Patient ID: [Patient ID Number]

Date: [Date of Prescription]

Prescribing Provider

Name: [Doctor's Name]

Clinic/Hospital: [Name of Clinic/Hospital]

Contact Information: [Phone Number, Email]

Prescription Details

After evaluating the patient's mobility challenges and considering their overall health condition, the following mobility aid is prescribed:

Type of Mobility Aid: [Type of Aid (e.g., walker, wheelchair, cane)]

Specifications: [Include any specific features or adjustments required]

Instructions for Use

The patient is advised to use this mobility aid as follows:

- [Instruction 1]
- [Instruction 2]
- [Instruction 3]

Follow-Up

Follow-up appointment scheduled for: [Date of Follow-Up]

Provider Signature: _____

Date: [Date of Signature]