Adult Care Facilities
Medical Equipment Waiver Addendum

Physician Name: _____

NYS License No.: _____

Address: _____

_____

Phone: _____

Fax: _____

Email Address: _____

Patient Name: _____

Date of Birth: _____

The below request has 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** ½ Side Rail ☐ Yes ☐ No
☐ **Enabling Device** Specific Type: _____
☐ **Trapeze**
☐ **Other** **Specify:** _____

Physician Signature _____

Date _____