WHEELCHAIRS PLUS
7719 Wurzbach Road
San Antonio, Texas 78229
210 949 1660 TEL
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Documentation for Stander

Date:

Client Name:	Medicaid Number:	D.O.B.	Height:	Weight:

1) Client's medical condition.

A. Diagnosis/involvement:

B. Function level:

2) Anticipated benefits expected from standing program:
3) Frequency, duration and amount of time of prescribed home standing program. (e.g. 45 minutes 3 x daily):
4) Length of time stander is anticipated to be needed:
5) Is client expected to be ambulatory? Yes: ☐ No: ☐

6) Prescribed stander

A. Manufacturer:	Model:	Price:
B. Accessories including prices:		
C. Growth and adjustment range of stander:		

Signature_____