SEQUOIA
Integrative Medical Services

SWO FORM

Name _____ Medicare ID: _____

DOB _____ Height: _____ Weight: _____ lbs Medicaid ID: _____

Description of DME/Medical Supplies	Quantity	Duration of Need for DME/Supplies

ICD10 Code	Brief Diagnosis Descriptor	Medical necessity/F2F Documentation

Wound Stages/Dimensions (if applicable):

Functionality/Mobility Status (if applicable):

Date last seen by Physician: _____ / _____ / _____ (Indicated date MUST be the date F2F was completed.)

Prescribing Physician Information:

Provider: _____

NPI: _____

Physician Signature: _____ Date: _____