Continuum
a CHC Solutions Company

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CONTINUUM CONNECT HOSPITAL BED ORDER FORM

Please attach face sheet w/ patient demographics & insurance info
Please attach clinical notes or any relevant documentation

PATIENT INFORMATION

Patient Name: _____ DOB: _____/_____/_____ Gender: ☐ Male ☐ Female

Language Pref.: ☐ English ☐ Spanish ☐ Other: _____

Patient cannot accept deliveries on the following days?
☐Mon ☐Tues ☐Wed ☐Thurs ☐Fri ☐Sat

Height:_____ Weight:_____

Emergency Contact Name/Phone Number: _____

DIAGNOSIS

Primary Diagnosis	**Secondary Diagnosis**
ICD-10 Code: _____	**ICD-10 Code:** _____
*Non-Specified Codes will not qualify for Primary Diagnosis	

PRODUCTS

Equipment	
☐ Manual Hospital Bed	
☐ Semi-Electric Hospital Bed	
☐ Full Electric Hospital Bed	
☐ Heavy Duty Hospital Bed	
☐ Other	
Order Date: _____/_____/_____	**Patients hip to hip measurement: _____** **Length of Need: _____ months (Numeric Form Only)**

Questions to determine medical necessity and justify a Hospital Bed

Does this patient require positioning of the body in ways not feasible with an ordinary bed due to a medical condition which is expected to last at least one month?	☐ Yes	☐ No
Does the patient require, for the alleviation of pain, positioning of the body in ways not feasible in an ordinary bed?	☐ Yes	☐ No
Does the patient require the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease or aspiration?	☐ Yes	☐ No
Does the patient require traction that can be only be attached to a hospital bed?	☐ Yes	☐ No
Does the patient require a bed height different than a fixed height hospital bed to permit transfer to chair, wheelchair or standing position?	☐ Yes	☐ No
Does the patient require frequent changes in body position and/or have an immediate need for a change in body?	☐ Yes	☐ No
Is the patient able to independently operate the control of a semi-electric or full electric hospital bed?	☐ Yes	☐ No

REFERRAL INFORMATION

Ref #: _____

Practice Name: _____ Fax: _____

Office Address: _____ Email: _____

Phone: _____ Preferred Method of Contact? ☐ Phone ☐ Fax ☐ Email

Contact Person: _____

Physician Name: _____ NPI#: _____ Phone: (_____)_____-_____ Ext. _____

Physician Signature: _____ Date: _____/_____/_____

I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing below, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed. I certify that my decision to prescribe this recommended product was solely based on my determination of medical necessity set forth herein. This document may serve as a confirmation of a verbal order and is also recorded in the patient's record.