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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?
Height: _____ Weight: _____ Mon Tues Wed Thurs Fri Sat
Emergency Contact Name/Phone Number: _____

DIAGNOSIS

Primary Diagnosis

ICD-10 Code: _____

*Non-Specified Codes will not qualify for Primary Diagnosis

Secondary Diagnosis

ICD-10 Code: _____

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

Table with 2 columns: Question and Yes/No response options. Questions include: 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? Does the patient require, for the alleviation of pain, positioning of the body in ways not feasible in an ordinary bed? 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? Does the patient require traction that can be only be attached to a hospital bed? Does the patient require a bed height different than a fixed height hospital bed to permit transfer to chair, wheelchair or standing position? Does the patient require frequent changes in body position and/or have an immediate need for a change in body? Is the patient able to independently operate the control of a semi-electric or full electric hospital bed?

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.