CHC SOLUTIONS, INC.

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# SUPPORT SURFACES GROUP 1 ORDER FORM

***Please attach face sheet w/ patient demographics & insurance info***

## 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

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

| | |
|---|---|
| ☐ | 5 Zone Foam Support Mattress |
| ☐ | Gel Overlay |
| ☐ | Alternating Pressure Pad |

## Indicate which of the following conditions describe the patient. (Check all that apply)

| | |
|---|---|
| ☐ | Completely immobile - i.e. patient cannot make changes in body position without assistance |
| ☐ | Limited mobility - i.e. patient cannot independently make changes in the body position without assistance |
| ☐ | Any pressure ulcer on the trunk or pelvis - *Please note that if the patient is not currently receiving wound care supplies from CHC Solutions, current wound detail and history is needed.* |
| ☐ | Impaired nutritional status |
| ☐ | Fecal or urinary incontinence |
| ☐ | Altered sensory perception |
| ☐ | Compromised circulatory status |

***If none of the above apply, attach a separate sheet documenting medical necessity for the equipment ordered.**

**Height:** _____ **Weight:** _____

**Hip-to-Hip Measurement:** _____

**Order Date:** _____/_____/_____

**Length of Need:** _____ **months**

## 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, 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.*

Call **1.800.220.5262** or visit **www.chcsolutions.com** for additional information.

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