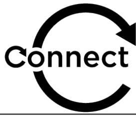

FAX: 1.888.248.2026
EMAIL: connect@chcsolutions.com

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

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 **1.888.248.1975** or visit **www.connectchc.com** for additional information.

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