



FAX: 1.888.248.2026

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SUPPORT SURFACES GROUP 2 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

AP Low Air Loss Mattress

Assure AL Low Air Loss Mattress

Low Air Loss Filter

Indicate which of the following conditions describe the patient.

Does the patient have multiple stage II pressure ulcers on trunk or pelvis? Yes No

Has the patient been on a comprehensive ulcer treatment program for at least the past month which has included the use of an alternating pressure or low air loss overlay which is less than 3.5 inches or a non-powered pressure reducing overlay mattress? Yes No

Over the past month, the patient's ulcer(s) has/have: Improved Worsened Same

Does the patient have large or multiple stage III or IV pressure ulcers 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.* Yes No

Has the patient had a recent (past 60 days) myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis? Yes No

If yes, please list date of surgery: _____

Was the patient on an alternating pressure or low air loss mattress or bed or an air fluidized bed immediately prior to recent (past 30 days) discharge from hospital or nursing facility? Yes No

Does the patient currently have a hospital bed? *(A hospital bed is required for the use of this product)* Yes No

Height: _____ Weight: _____

Order Date: ____/____/____

Hip-to-Hip Measurement: _____

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.