MEDICAL PHARMACY
1213 MAIN STREET
WILLIMANTIC, CT. 06226
PH: (860) 423-1661
F: (860) 456-2944

WWW.MEDICALPHARMACYCT.COM\

MEDICAL PHARMACY LTC
1197 MAIN STREET
WILLIMANTIC, CT. 06226
PH: (860) 423-1661
F: (860) 423-3861

CHAD WOJNAR R.PH., PRESIDENT
JACK LOVELAND R. PH., VICE PRESIDENT

Physician's Order Form for Group 1 Support Surface

Item Description:_____ **Date Ordered:** ___/___/_____

Patient's Name: _____ **DOB:** _____/_____/_____

Patient's Address: _____

Insurance ID #: _____

*The information below **may not** be completed by the supplier or anyone in a financial relationship with the supplier.*

****Indicate which of the following conditions best describe the patient, check all that apply.****

1. Completely immobile- i.e. patient can not make changes in body position without assistance. ☐ Yes ☐ No
2. Limited mobility- i.e. patient can not independently make changes in body position significant enough to alleviate pressure. ☐ Yes ☐ No
3. Any pressure ulcer on the trunk or pelvis. ☐ Yes ☐ No
4. Impaired nutritional status. ☐ Yes ☐ No
5. Fecal or urinary incontinence. ☐ Yes ☐ No
6. Altered sensory perception. ☐ Yes ☐ No
7. Compromised circulatory status. ☐ Yes ☐ No

ICD-10 Code:_____ **Length of Need:** _____

Frequency of Use:_____ **Height:** ____'____" **Weight:** _____**lbs**

If none of the above applies, attach a separate sheet documenting medical necessity for the item ordered.

Physician Name:_____ **NPI #** _____

Physician's Address:_____

I, the undersigned, certify the above prescribed equipment and/or supplies are medically necessary as part of my treatment for this patient. In my opinion, the equipment and/or supplies prescribed are both reasonable and necessary for accepted standards of medical practice and treatment of this patient's condition. Neither the equipment and/or supplies are being prescribed as "convenience equipment".

Physician's Signature :_____**Date** ____/____/_____

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1197 MAIN STREET
WILLIMANTIC, CT. 06226
PH: (860) 423-1661
F: (860) 423-1200

CHAD WOJNAR R.PH., PRESIDENT **JACK LOVELAND R. PH., VICE PRESIDENT**

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