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

Physician's Order Form for Hospital Bed

Equipment Ordered:_____

Date Ordered: ___/___/_____ ☐ Initial ☐ Renewal **Date of Face to Face:** ___/___/_____

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

Patient's Address: _____

_____

Insurance ID #: _____ **Height:** ____'____" **Weight:** _____**lbs**

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

**** Please answer the following questions ****

1. Does the 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? ☐ Yes ☐ No
2. Does the patient require, for the alleviation of pain, positioning of the body in ways not feasible with an ordinary bed? ☐ Yes ☐ No
3. 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? ☐ Yes ☐ No
4. Does the patient require traction which can only be attached to a hospital bed? ☐ Yes ☐ No
5. Does the patient require a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair, or standing position? ☐ Yes ☐ No
6. Does the patient require frequent changes in body position and/or have an immediate need for a change in body position? ☐ Yes ☐ No

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** ____/____/_____

LC