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

Physician's Order Form for Group 2 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. Does the patient have multiple stage II pressure ulcers on the trunk or pelvis? ☐ Yes ☐ No
2. 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 or mattress? ☐ Yes ☐ No
   - Over the past month, the patient's ulcer(s) has/have: **A) Improved** ◯ ◯ **B) Remained the same**, or **C) Worsened** ◯
3. Does the patient have large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis? ☐ Yes ☐ No
4. Has the patient had a recent (within the past 60 days) myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis? If yes, date of surgery:_____ ☐ Yes ☐ No
5. Was the patient on an alternating pressure or low air loss mattress or bed or an air fluidized bed immediately prior to a recent (within the past 30 days) discharge from a hospital or nursing facility? ☐ Yes ☐ No

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

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

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