Hospital Bed - Medicare Questionnaire

DETAILED WRITTEN ORDER FOR DURABLE MEDICAL EQUIPMENT

Prescriber's Name (Print) _____ **NPI** _____
REQUIRED *REQUIRED*

Order Date _____
REQUIRED

Prescriber's Signature X _____ **Signature Date** _____
STAMPED SIGNATURE NOT ACCEPTED *REQUIRED*

Please sign, date and fax back to Forester Family Medical Supply.

PATIENT INFORMATION

Patient Name _____ **DOB** _____

Phone#: _____ **Height:** _____ **WT:** _____

DURABLE MEDICAL EQUIPMENT

1) Does the patient have a medical condition, which requires positioning of the body in ways not feasible with an ordinary bed? (Elevation of the head/upper body less then 30 degrees does not usually require use of a hospital bed). _____

2) Does the patient require positioning of the body in ways not feasible with an ordinary bed in order to alleviate the pain? _____

3) Does the patient require the head of the bed to be elevated more then 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problem with aspiration? Pillows or wedges must have been considered and ruled out. _____

4) Does the patient require traction equipment, which can be only attached to a hospital bed? _____

5) Does the patient require frequent changes in body position and/or has an immediate need for change in body position? _____

6) Does the patient require a bed height different than a fixed height hospital bed to permit transfers to a chair, wheelchair, or standing position? _____

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