WOUND CARE SOLUTIONS, INC.

HOSPITAL BED ACCESSORIES

WRITTEN ORDER PRIOR TO DELIVERY

PLEASE FAX BACK TO 312-738-2395 PHONE: 312-738-2330

Patient Name:_____ Patient DOB:_____

Patient Address:_____ City: _____ SS#/ HICN:_____

State:___ Zip Code:_____ Patient Telephone #:_____

Patient HEIGHT:_____ Patient WEIGHT:_____ Patient HIP MEASUREMENT:_____

ORDER DATE : _____

DATE PATIENT LAST SEEN_____D/C DT_____

Diagnosis: _____

(ICD-10 CODES) _____

Prognosis: _____

GEL / FOAM OVERLAY MATTRESS *(E0185, QTY: 1) Indicate which of the following conditions describes* the wheelchair patient:

☐ 1:**LIMITED MOBILITY OR** ☐ **2: ANY PRESSURE ULCER ON TRUNK OR PELVIS** ☐ **3: COMPLETELY IMMOBILE**

***AND* (CHECK ALL THAT APPLY):**

☐ **a. IMPAIRED NUTRITIONAL STATUS** ☐ **c. ALTERED SENSORY PERCEPTION**

☐ **b. FECAL OR URINARY INCONTINENCE** ☐ **d. COMPROMISED CIRCULATORY STATUS**

☐ **Description: *TRAPEZE FOR HOSPITAL BED*** (E0910 QTY:1)

Y N Does the patient need this device to sit up because of respiratory condition, to change body position for other medical reasons, or to get in or out of bed?

☐ ☐

☐ **Description: *HOYER, PATIENT LIFT*** *(E0630 QTY: 1)*

Y N

☐ ☐ Does the patient require lift because transfer between bed and chair, wheelchair or commode requires assistance of more than one person and, without the use of the lift, the paitent would be bed confined?

FULL BODY SOLID SLING

☐ **MEDIUM**

☐ **LARGE**

☐ **EXTRA-LARGE**

FULL BODY MESH SLING WITH COMMODE OPENING

☐ **MEDIUM**

☐ **LARGE**

☐ **EXTRA-LARGE**

Description: *COMMODE 3-IN-1 (up to 300 lbs) Code: E0163* **Quantity:** 1

(***CHECK)*** appropriate answer(s):

☐ YES ☐ NO ☐ N/A Is the patient confined to one level of the home and there is no toilet on that level?

☐ YES ☐ NO ☐ N/A Is the patient confined to the home and there are no toilet facilities in the home?

☐ YES ☐ NO ☐ N/A Is the patient confined to a single room?

Description: *COMMODE 3-IN-1 Drop Arm (up to 300 lbs) Code: E0165* **Quantity:** 1

(***CHECK)*** appropriate answer(s):

☐ YES ☐ NO ☐ N/A Is the patient confined to one level of the home and there is no toilet on that level?

☐ YES ☐ NO ☐ N/A Is the patient confined to the home and there are no toilet facilities in the home?

☐ YES ☐ NO ☐ N/A Is the patient confined to a single room?

☐ YES ☐ NO ☐ N/A Are detachable arms needed to facilitate transfer of patient or body requries extra width?

I, the undersigned, certify that the above prescribed equipment/supplies is medically necessary as part of my treatment for this patient. In my opinion, the equipment prescribed is reasonable and necessary for accepted standards of medical practice and treatment of this patient's condition and has not been prescribed as "convenience equipment."

Physician Name: _____ Physician Telephone # _____

Physician Address: _____ City:_____ State: _____ Zip_____

Physician Signature: _____NPI#:_____Date:_____

Note: Please maintain a copy of the Written Order, which must be kept on file for 7 years or longer if, required by state law.