Physician's Choice
HOME MEDICAL SUPPLY
1509 Doctors Drive
Bossier City, La 71111
Phone: (318) 746-6288
Fax: (318) 746-7911
NPI: 1255382123

Hospital Bed Order

Patient Name: _____ **D.O.B:** _____

Rx Date: _____ **Length of Need:** _____

Height: _____ **Weight:** _____

ICD-10 Code: _____

Equipment Needed:

Please Check All That Apply

- ☐ Semi-Electric Hospital Bed (E0260)
- ☐ Full Length Rails (E0310)
- ☐ Half Length Rails (E0305)
- ☐ HD Electric Hospital Bed (E3303) *

ADDITIONAL MEDICAL INFORMATION:

Please check all that apply. Patient must meet one of the criteria to qualify for insurance coverage.

The patient has a medical condition which requires positioning of the body in ways not feasible with an ordinary bed because of:

- ☐ The patient has a medical condition which requires head/upper body elevation great than 30 degrees.
- ☐ The patient has a medical condition that requires positioning to alleviate pain.
- ☐ The patient requires traction equipment which can only be attached to a hospital bed.

Accessories Needed:

☐ Trapeze Bar (E0910)	☐ Free Standing Trapeze (E0940)	Icd-10:
☐ Hoyer Lift w/ patient sling (E0630)	Size: ☐ Sm ☐Med ☐Lg	Icd-10:
☐ Alternating Pressure Mattress (E0277) **	Icd-10:	
☐ Alternating Pressure Pad (E0181) **	Icd-10:	

**Must be over 450 lbs.*

***Stage III or IV wound documentation required*

Physician's Signature: _____ **NPI #:** _____

Printed Name: _____ **Signature Date:** _____

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MANUAL WHEELCHAIR (MWC) ORDER

Patient Name: _____ **D.O.B:** _____ **Date:** _____
HT: _____ **WT:** _____ **Length of need:** _____ **Daily Use:** _____
ICD-10 Diagnosis': _____

Does the patient have mobility limitation that significantly impairs his/her ability to participate in a MRADL? ☐ Yes ☐ No

Please check all activities patient is **unable** to complete safely?

☐ **FEEDING** ☐ **TOILETING** ☐ **DRESSING** ☐ **GROOMING** ☐ **BATHING** ☐ **OTHER**

Can the patient overcome their mobility limitation by using a cane or a walker? ☐ Yes ☐ No

Does the patient have enough room in their home to operate the MWC requested? ☐ Yes ☐ No

Will the use of a MWC significantly improve the patient's ability to participate in MRADLS? ☐ Yes ☐ No

Has the patient expressed an unwillingness to use a manual wheelchair? ☐ Yes ☐ No

Does the patient have the physical strength and mental capabilities to safely propel a **standard** MWC? ☐ Yes ☐ No

Does the patient have a spouse or caregiver who is able to assist with the MWC? ☐ Yes ☐ No

Is the patient willing and able to self-propel in the wheelchair that has been ordered? ☐ Yes ☐ No

The Patient will require the use of a:
☐ K0003 (UNDER 250)
☐ K0006 (250-300)
☐ K0007 (300 & UP)

Please select any other requirements that the patient will need for the wheelchair:

☐ SAFETY BELT ☐ CUSHIONS ☐ HEEL LOOPS ☐ EXTRA-SEAT WIDTH/DEPTH

☐ ELEVATED LEG RESTS ☐ ANTI-TIPPERS ☐ LIMB SUPPORT ☐ RECLINING BACK

OTHER: _____

ORDERING PHYSICIAN: _____ **NPI** _____
PHYSICIANS SIGNATURE: _____ **DATE:** _____