Physician's Order

Hospital Beds

Patient Information

Name:____________________________________

Address:____________________________________

City, State, Zip:______________________________

Medicare#:______________________ DOB:________

Phone: ______________Height:_____ Weight _______

PROFESSIONAL. MEDICAL HOMECARE
4869-C MEMORIAL DRIVE
STONE MOUNTAIN, GA 30083
Phone: 404-292-9190
Fax: 404-508-9225
NPI Number: XX2287131

Diagnosis	Description

Length of Need[ ]______ Months[ ]Lifetime______

Please answer the following questions.

Yes No 1.) Does the patient have a medical condition which requires positioning of the body in ways not feasible with an ordinary bed?

Yes No 2.) Does the patient require positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain?

Yes No 3.) Does the patient require the head of the bed to be elevated more than 30 degrees most of the time due congestive heart? failure, chronic pulmonary disease, or problems with aspiration

Yes No 4.) Does the patient require traction equipment that can only be attached to a hospital bed?

Yes No 5.) Does the patient require frequent changes in body position?

Based upon the above information, the following items are needed by this patient for the stated length need:

Date	Check Items(s)	Quantity	HCPC	Description
		1.00	E0260 RRKHKX	SEMI ELECTRIC HOSPITAL BED

1, the undersigned, certify that the above prescribed equipment and/or supplies are reasonable and medically necessary as part of treatment from this patient. The need and medical necessity for the above listed equipment and/or supplies are documented in the patient's medical record and are available upon request.

Physician's Signature: ________________________ Date: ____________

Physician Name:__________________________ NPI Number:__________________

Address:________________________________ Phone Number:_________________

City, State, Zip:__________________________ Fax Number:__________________