CORK MEDICAL

Specialty Mattress Order Form

Referred By: _____ Phone: _____ Fax: _____

Physician's Full Name: _____ NPI: _____

Patients Name: _____ DOB: _____ Ht/Wt: _____

HOSPITAL BED & SUPPORT SURFACE PRESCRIPTION

- ☐ (1) Semi-Electric Hospital Bed with Alternating Pressure/Low Air Loss Mattress *(Position changes required through night)*
- ☐ (1) Semi-Electric Hospital Bed with Non Powered Group 2 Mattress *(Position changes required through night)*
- ☐ (1) Standard Hospital Bed with Alternating Pressure/Low Air Loss Mattress *(Position changes not required through night)*
- ☐ (1) Other _____
- ☐ HD Package *(Patient weighs more than 350 lbs.)*

SEATING AND TRANSFER PRESCRIPTION

- ☐ (1) Wheelchair Cushion
- ☐ (1) Wheelchair Back Cushion
- ☐ (1) Trapeze Bar *(Patient needs assistance re-positioning in bed)*
- ☐ (1) Hoyer Lift *(Patient needs transferring assistance)*

QUALIFICATION

Length of Need: *(# of months, 99= lifetime)* _____ Face to Face Assessment Date *(Medicare Only)* _____

Corresponding ICD-10 Codes:

_____–_____ _____–_____ _____–_____ _____–_____

STATEMENT OF ORDERING PHYSICIAN - GROUP II MATTRESS *(ANSWER ALL QUESTIONS)*

Y N Does the patient have multiple stage 2 pressure ulcers in the hip, trunk or pelvis?

Y N Has the patient utilized a Group 1 pressure relieving overlay or mattress and participated in a comprehensive ulcer treatment program for at least the past 30 days?

1 2 3 Over the past month, the patients ulcer(s) has/have: 1)Improved 2)Remained the same 3)Worsened

Y N Does the patient have a large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis?

Y N Has the patient had a recent (past 60 days) myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis? Date of Surgery: _____

Y N Was the patient on a Group 2 or Group 3 support surface immediately prior to a recent (past 30 days) discharge from a hospital or nursing facility?

Y N Is the patient on a care plan by physician or home care nurse which includes appropriate turning and positioning, appropriate wound care, appropriate management of moisture/incontinence, appropriate nutritional assessment and intervention consistent with the overall plan of care?

Order Date: _____

Physician Signature: _____ Signature Date: _____