



Please fax your patient's insurance and demographic information along with this form.

BOARDMAN (330) 758-0595 Fax (330) 726-2229

CANTON (330) 492-4300 Fax (330) 492-7886

CLEVELAND (216) 341-7020 Fax (216) 341-7023

EAST LIVERPOOL (330) 385-6412 Fax (330) 385-3255

GIRARD (330) 545-6700 Fax (330) 545-5555

SHARON (724) 962-5670 Fax (724) 962-5673

WARREN (330) 395-7252 Fax (330) 373-1190

TOLL FREE 1-800-443-3390 TOLL FREE FAX 1-800-952-5352

SUPPORT SURFACE E-Z SCRIPT

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient Phone #: \_\_\_\_\_

Ordered By: \_\_\_\_\_

Address: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Diagnosis/Diagnosis Code: \_\_\_\_\_

Duration of Need: \_\_\_\_\_

Alternating Pressure Pad & Pump

Gel Overlay

Sof-Care

( check all that apply )

- Completely immobile - i.e., patient cannot make changes in body without assistance.
Limited mobility - i.e., patient cannot independently make changes in body position significant enough to alleviate pressure.
Any stage pressure ulcer on the trunk or pelvis.
Impaired nutritional status.
Facal or urinary incontinence.
Altered sensory perception.
Compromised circulatory status.

Low Air Loss

( check all that apply )

- Multiple stage II pressure ulcers located on the trunk or pelvis.
Patient has been on a comprehensive ulcer treatment program for at least the past month which has included the use of an appropriate group 1 support surface.
The ulcer have worsened or remained the same over the past month.
Large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis.
Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis ( surgery within the past 60 days).
The patient has been on a group 2 or 3 support surface immediately prior to a recent discharge from a hospital or nursing facility (discharge within the past 30 days).

Hospital Bed

- Manual Hospital Bed, Variable Height Hospital Bed, Semi-electric Hospital Bed, Half Rails, Full-electric Hospital Bed, Full Rails, Fixed Height Hospital Bed

- Accessories: Bed-mount Traction, Trapeze: Bed-mount, Free-standing, Patient Lift

I certify that the medical necessity information above is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

Printed Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ NPI #: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_