Hospital Bed Written Order Request Form

Date: ________________

Provider:  Sullivan’s Pharmacy and Medical Supply
Address:  1 Corinth St. Roslindale, MA 02131
Phone:  617-325-0013       Fax:   617-323-8792

Patient:

<table>
<thead>
<tr>
<th>Last</th>
<th>First</th>
<th>DOB</th>
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<tr>
<th>Street</th>
<th>City</th>
<th>State</th>
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Diagnosis: __________________________________________  ICD-9: _____  ICD-10: ______

Diagnosis: __________________________________________  ICD-9: _____  ICD-10: ______

Height _______  Weight _______

Section A: Basic Qualifying Information for a Fixed Height Hospital Bed

Please check any statements that apply
☐ 1. The patient has a medical condition that requires positioning of the body in ways not feasible with an ordinary bed
☐ 2. The patient requires positioning of the body in ways not feasible with an ordinary bed to alleviate pain
☐ 3. The patient requires the head of the bed to be elevated more than 30 degrees most of the time due to Congestive Heart Failure, Chronic Pulmonary Disease, or problems with aspirations. Pillows or wedges must have been considered or ruled out
☐ 4. The patient requires traction equipment, which can only be attached to a hospital bed

Section B: Order / Statement of Need

Please Check the type of hospital bed you are ordering. Note: In addition to the required qualifying statement above, additional requirements are listed for the following type of beds:
☐ Semi Electric Hospital Bed
   The above patient meets one of the above criteria and requires frequent changes in the body position and/or has an immediate need
☐ Heavy Duty Hospital Bed
   The above patient meets one of the criteria in Section A and weighs more than 350 pounds but does not exceed 600 pounds

Accessories:
☐ Side Rails:  ☐ Full Length  ☐ Half Length
☐ Trapeze Equipment  ☐ Required to help patient sit up or change body position due to a medical condition
☐ Over The Bed Table
☐ Alternating Pressure Pad (special conditions apply – requires additional CMN)
☐ Gel Overlay Mattress

Length of Need (required):  ☐ Indefinite (99 months)  ☐ ________ Months

Doctor’s Name: ________________________________________  NPI#: ____________________

Doctor’s Address: ________________________________________

Doctor’s Phone #: ____________________  Fax #: ____________________

Sign: ________________________________________  Date: ____________________