Statement of Ordering Physician
Group 2 Support Surfaces

Patient Name:_____

HIC # _____

Cost information (to be completed by the supplier):

Supplier's charge _____

Medicare fee schedule allowance_____

The information below may not be completed by the supplier or anyone in a financial relationship with the supplier.

Circle **Y** for **Yes**, **N** for **No**, **D** for **Does Not Apply**, unless otherwise noted.

Y N D 1) Does the patient have multiple stage II pressure ulcers on the trunk or pelvis?

Y N D 2) Has the patient been on a comprehensive ulcer treatment program for at least the past month which has included the use of an alternating pressure or a low air loss overlay which is less than 3.5 inches, or a nonpowered pressure-reducing overlay or mattress.

1 2 3 3) Over the past month, the patient's ulcer(s) has/have:
1) improved; 2) remained the same; 3) worsened

Y N D 4) Does the patient have large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis?

Y N D 5) Has the patient had a recent (within the past 60 days) myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis?
If yes, give date of surgery: _____

Y N D 6) Was the patient on a alternating pressure or low air loss mattress or bed or an air fluidized bed immediately prior to a recent (within the past 30 days) discharge from a hospital or nursing facility?

Estimated length of need (# of months): _____ (99=lifetime) _____

Physician name (printed or typed): _____

Physician signature: _____

Physician NPI: _____

Date Signed: _____