

**Statement of Ordering Physician  
Group 1 Support Surfaces**

Attn: Cate/Molly  
Fax: 216-252-4930  
Phone: 216-252-3900

Patient name: \_\_\_\_\_

Patient address: \_\_\_\_\_

HIC #: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Cost information (to be completed by the supplier):

Supplier 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 to describe the patient:**

- 1) Y N D Completely immobile? – i.e. patient cannot make changes in body position without assistance.
- 2) Y N D Limited mobility? – i.e. patient cannot independently make changes in body position significant enough to alleviate pressure.
- 3) Y N D Any pressure ulcer on the trunk or pelvis?  
If YES: Stage \_\_\_\_\_ Size \_\_\_\_\_
- 4) Y N D Impaired nutritional status?
- 5) Y N D Fecal or urinary incontinence?
- 6) Y N D Altered sensory perception?
- 7) Y N D Comprised circulatory status?
- 8) Y N D Are you supervising the use of this device?
- 9) Y N D Is there a trained full-time caregiver to assist and manage all aspects involved with the use of the mattress?

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

If none of the above apply, attach a separate sheet documenting medical necessity for the item ordered.

Physician name (printed or typed): \_\_\_\_\_

Physician signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Physician NPI: \_\_\_\_\_ Date of Last Physician Exam: \_\_\_\_\_

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