GROUP ONE-ORDER FORM/RX

DATE OF ORDER: **Length of Need:______**

PATIENT NAME: DOB:
ADDRESS: HT:______ WT:_____
CITY: ZIP:
PHONE:

ICD 10 Code1________________ ICD 10 Code2_______________
ICD 10 Code3________________ ICD 10 Code4_______________

MEDICAL EQUIPMENT ORDER:

____Gel Overlay ____APP ____Therapeutic Mattress

Cost Information (To Be Completed By Provider):
Suppliers Cost:____ Medicare Fee Schedule Allowance:____

1-7 Below May Not Be Completed By The Supplier Or Anyone In A Financial Relationship With The Supplier

Indicate which of the following conditions describe the patient. Check all that apply:

1.__ Completely immobile - i.e. patient cannot make changes in body position without assistance.

2.__ Limited Mobility - i.e.patient cannot independently make changes in body position significant enough to alleviate pressure.

3.__ Any pressure ulcer(s) on the trunk or pelvis.

4.__ Impaired nutritional status.

5.__ Fecal or urinary incontinence.

6.__ Altered sensory perception.

7.__ Compromised circulatory status.

Doctors Name: NPI:

Address:

Fax # Phone #

Doctors Signature ________________________________ Date__________