

HOSPITAL BED REQUEST

***Please complete form in full ***

Patient Name: _____

DOB: _____

Weight: _____

Date of Request: _____

ICD-10 Diagnosis Codes: _____

Clinical Issues (please circle yes or no)

1. Does the patient have a medical condition which requires positioning of the body in ways not feasible in an ordinary bed (elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed)? **YES NO**
2. Does the patient require positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain? **YES NO**
3. Does the patient require 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 aspiration that a pillow or wedge will not accommodate? **YES NO**
4. Does the patient require traction equipment which can only be attached to a hospital bed? **YES NO**
5. Does the patient require a semi-electric bed because patient requires frequent changes in body position and/or have an immediate need for change in the body position? **YES NO**
6. Does the patient require a heavy duty extra wide bed and weigh more than 350 lbs but does not exceed 600 pounds? **YES NO**
7. Does the patient require the use of a trapeze bar to sit up because of a respiratory condition or to change body positions or to get in and out of bed? **YES NO**
8. Does the patient require siderails or safety enclosures because of the patient's condition and they are in integral part of or an accessory to the bed? **YES NO**
9. Does the patient have one of the following below (if yes, please indicate all that apply)? **YES NO**
 - Severe Arthritis
 - Severe Cardiac Condition
 - Spinal cord injuries, multiple limb amputee, stroke patient
 - Severe debilitating disease and conditions

Physician Signature

NPI #

Physician Print Name