NORTHEAST MEDICAL PRODUCTS, INC
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HOSPITAL BED ORDER FORM

Patient Name ____ TEL _______________________

Address ____

Diagnosis codes ____________________________________Ht___________ Wt _____________

DOB ___________________ Length of Need ______________ Start Date ___________________

Equipment ordered:

_____ E0260 Hospital bed, semi electric, with mattress, rails (check 1): ___ Full Rail ___ Half Rail
_____ E0303 Hospital bed, heavy duty (350-600lbs), rails, mattress

Coverage Questions:

Y N Does the patient have a medical condition which requires positioning of the body in ways not feasible with an ordinary bed?
Y N Does the patient require positioning of the body in ways not feasible with an ordinary bed in order to alleviate pain?
Y N 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, COPD, or problems with aspiration?
Y N Have pillows and wedges been considered and ruled out?
Y N Does the patient require traction equipment, which can only be attached to a hospital bed?
Y N Does the patient require a bed height different than a fixed height hospital bed to permit transfers to chair, wheelchair or standing position?
Y N Does the patient require frequent changes in body position and/or has an immediate need for a change in body position?
Y N Does the patient weigh 350-600 pounds?

PLEASE SUPPLY A COPY OF THE NOTES FROM THE FACE-TO-FACE VISIT
(Please be sure to sign, date, and NPI the end of the patient notes)

Physician Name____

Address ____

Phone ______________________Fax ____________________NPI ___________________

____
Physician Signature Date