State of Illinois
Department of Healthcare and Family Services

HOSPITAL BED QUESTIONNAIRE

PATIENT INFORMATION

Name: Haynes Tonia Recipient ID: XXL901067807

Diagnosis: _____ Height: 4'11 Weight: 280 LB

☐ Semi-Electric Hospital Bed ☐ Full Electric Hospital Bed

Does the patient have a caregiver? ☐ Yes ☐ No

Is the patient left alone for long periods of time? ☐ Yes ☐ No
If yes, how many hours per day? _____

Can the patient ambulate? ☐ Yes ☐ No

Is the patient bedridden? ☐ Yes ☐ No
If bedridden, what is the transfer method? _____

Is condition permanent? ☐ Yes ☐ No
If no, what is duration of need? _____

Can patient reposition self? ☐ Yes ☐ No

Is the patient able to operate controls on the hospital bed? ☐ Yes ☐ No

Does the patient require positioning not feasible in a standard bed? ☐ Yes ☐ No
If yes, explain: _____

Is this for post-op use? ☐ Yes ☐ No
If yes, date of surgery: _____

Prognosis: _____

Physician's signature: _____ Date: _____

Print Form

Advanced Medical Supply
3322 N. Milwaukee Avenue, Chicago, IL 60641
Phone: (773) 205-6993 Fax: (773) 205-6994

DETAILED WRITTEN ORDER

Patient's Name:	Tonia Haynes	
Address:	479 La Fox St South Elgin, Il 60177	
Phone:	773-420-8634	
Dob:	02/28/1970	
Insurance Name And Id.	Medicare:	Medicaid: 071250542
Other Insurance Name And Id : Blue Cross Blue Shield Il Mmcp Xxl901067807		

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PRODUCT DESCRIPTION	QUANTITY
Hospital Bed With Rails And Mattress	1
Alternating Air Overlay Pad With Pump	1

Height: 4'11'' Weight: 280 LB

LENGTH OF NEED (# OF MONTHS): 99=LIFETIME

DIAGNOSES:

[ ] Alzheimer's disease
[ ] Amputation of_____
[ ] Unsteady gait
[ ] Bronchial Asthma
[ ] Dysphagia
[ ] Malnutrition
[ ] Chronic Incontinence [ ] Urine [ ] Stool
[ ] CVA
[ ] CHF
[ ] Degenerative Osteoarthritis of_____
[ ] Diabetes Mellitus
[ ] Dementia
[ ] Dizziness
[ ] Emphysema/COPD/Asthma
[ ] Fracture of_____
[ ] Generalized Body Weakness
[ ] Hernia (inguinal) (umbilical) (ventral)
[ ] Organic Brain Syndrome
[ ] Osteoporosis_____
[ ] Paralysis
[ ] Parkinson's disease
[ ] Varicose Veins/ Venous Insufficiency
[ ] Pendulous Abdomen
[ ] Loss of Appetite
[ ] Loss of Weight
[ ] Renal Failure
[ ] S/P CVA/Hemiparesis
[ ] Carpal Tunnel Syndrome
[ ] S/P Open Heart Surgery
[ ] Debility
[ ] Spondylosis (cervical) (lumbar)
[ ] Sprain/Strain of_____
[ ] HTN

I, the undersigned, certify that the above prescribed supplies/equipment are medically necessary for this patient's well being. In my opinion, the supplies are both reasonable and necessary to the accepted standards of medical practice in treatment of this Patient's condition and are not prescribed as convenience supplies. By signing this form, I am confirming that the above information is accurate.

DOCTOR'S INFORMATION

Doctor's Signature: _____ Date:_____
Print Name: _____ NPI#: _____
Facility Name: _____
Address _____
Phone: _____ Fax: _____