State of Illinois
Department of Healthcare and Family Services

HOSPITAL BED QUESTIONNAIRE

PATIENT INFORMATION

Name: Merritt, Kenyatta Recipient ID: 217122449

Diagnosis: _____ Height: 5'4 " Weight: 121 lbs

☒ 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: _____

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

CERTIFICATE OF MEDICAL NECESSITY

Patient Name: Merritt, Kenyatta

DOB: 11/23/1994 HEALTH INSURANCE CLAIM No: 217122449

Address: 6353 S Langley Ave Apt 3N Chicago IL 60637

Phone: 312-312-1450

Rx

PRODUCT DESCRIPTION	QUANTITY
Pull ups/Diapers	200
Liners	120
Underpads	150
Gloves	200

Height: 5'4 " Weight: 121 lbs

REFILLS: 11

DIAGNOSES:

_____

_____

_____

[ ] Stress incontinence (female) (male)
[ ] Urge incontinence
[ ] Incontinence without sensory awareness
[ ] Post-void dribbling
[ ] Nocturnal enuresis
[ ] Continuous leakage
[ ] Unspecified urinary incontinence
[ ] Mixed incontinence
[ ] Overflow incontinence
[ ] Other specified urinary incontinence
[ ] Incomplete defecation

[ ] Fecal smearing
[ ] Fecal urgency
[ ] Full incontinence of feces
[ ] Drug induced retention of urine
[ ] Other retention of urine
[ ] Retention of urine, unspecified
[ ] Feeling of incomplete bladder emptying
[ ] Generalized Body Weakness
[ ] Degenerative Osteoarthritis of_____
[ ] Autistic Disorder
[ ] Organic Brain Syndrome

[ ] Emphysema/COPD/Asthma
[ ] Dementia
[ ] Diabetes Mellitus
[ ] Renal Failure
[ ] CHF
[ ] Dysphagia
[ ] CVA
[ ] Debility
[ ] Paralysis
[ ] Parkinson's disease
[ ] 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: _____