



Special Decubitus Mattress Questionnaire

Patient Name: JAIME PATRICIO DOB: 07/12/1981 RIN: 036386373

Individual answers to all of the questions are required for rental consideration of pressure pads and mattress overlays. These questions should be answered by the home health agency registered nurse or the attending physician; all of the information must be reviewed and signed by the attending practitioner. An updated form is needed for each renewal that includes a dated wound assessment less than seven days old at the time of submission of the request.

1. Provide complete list of primary and secondary diagnoses as well as comorbidities and complicating factors such as chemotherapy, transplant recipient, dementia, obesity, nutritional deficiencies, mobility limitations, impaired sensation, hip or knee replacement, fracture, and caregiver health impairments.

2. Provide complete description of any areas of skin breakdown including etiology (pressure, surgical, vascular-venous stasis/arterial, neuropathic/diabetic, traumatic), measurements (length x width x depth), wound bed characteristics (granulation tissue, slough, and eschar), presence of infection, margins for tunneling and undermining, drainage (type and amount), age of wound(s), and staging for pressure wounds.

3. Is the patient presently on a pressure-relief system or been on an ulcer treatment program for at least the last month that has included the use of a non-powered pressure reducing overlay/mattress or alternating pressure pad? Describe further.

4. Provide details of past and present wound treatment plan that include but are not limited to the following as relevant:

- a. Education of patient and caregivers
- b. Optimization of nutritional deficiencies
- c. Treatment of anemia
- d. Incontinence management
- e. Measures to offload pressure and reduce risk of shear
- f. Improvement of glucose control for diabetics
- g. Infection of wound and/or osteomyelitis
- h. Topical antimicrobials
- i. Growth factors, skin substitutes, electromagnetic therapy, electrical stimulation, hyperbaric oxygen, thermal ultrasound, topical collagen, and extracellular matrix protein
- j. Compression for venous insufficiency
- k. Revascularization for arterial insufficiency
- l. Surgical intervention (flap, graft)
- m. Debridement (surgical, enzymatic)
- n. Negative pressure wound therapy
- o. Low intensity ultrasound saline therapy

Practitioner's Signature with degree:

Date

NPI: _____ Office Phone #: _____ Fax: _____



Standard Manual Wheelchair Questionnaire

Participant's Name JAIME PATRICIO RIN 036386373 Birth Date 07/12/1981

Height 4'11" Weight 103 lb Participant's Hip Width 15"

Procedure code and description of wheelchair
K0003 - Lightweight Manual Wheelchair

Weight capacity of wheelchair 300 lb Width of wheelchair 16"

Diagnosis

Current ambulation status

Upper body control and strength

Does participant have the ability to self propel? Yes ☐ No ☐

If not, why?

If the participant is unable to safely self-propel the manual wheelchair does he/she have a caregiver who is available, willing, and able to provide assistance with the wheelchair? Yes ☐ No ☐

Does the participant need wheelchair to meet activities of daily living over the use of a walker or cane? Yes ☐ No ☐

If not, why?

Is this being requested for temporary use for injury or post op? Yes ☐ No ☐

If yes, date of injury or surgery _____ Expected duration of need _____

*All requests for renewal of post surgical/post injury wheelchairs will require updated MD script along with copy of MD clinical follow-up progress note.

Will this manual wheelchair meet participant's long term needs (3-5 years) or will participant need a customized wheelchair?

Physician's Name _____ Telephone Number _____

Attending Physician's Signature _____ Date Signed _____



HOSPITAL BED QUESTIONNAIRE

PATIENT INFORMATION

Name: JAIME PATRICIO

Recipient ID: 036386373

Diagnosis: _____

Height: 4'11"

Weight: 103 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