State of Illinois
Department of Healthcare and Family Services

HOSPITAL BED QUESTIONNAIRE

PATIENT INFORMATION

Name: SCODEZE BAKER

Recipient ID: 089873814

Diagnosis: _____

Height: 5'6"

Weight: 100 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

State of Illinois
Department of Healthcare and Family Services

Standard Manual Wheelchair Questionnaire

Participant's Name SCODEZE BAKER RIN 089873814 Birth Date _____

Height 5'6" Weight 100 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

HFS 3701L (N-8-13)