



## HOSPITAL BED QUESTIONNAIRE

### PATIENT INFORMATION

Name: JUANA CEBALLOS

Recipient ID: XOG911915486

Diagnosis:

Height: 4'11" Weight: 156 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 JUANA CEBALLOS

RIN XOG911915486

Birth Date 06-27-1965

Height 4'11"

Weight 156 LB

Participant's Hip Width 16"

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 \_\_\_\_\_