Statement of Ordering Physician
Group 2 Support Surfaces

Patient name: _____

HIC #: _____

Cost information (to be completed by the supplier):

Supplier's charge _____

Medicare fee schedule allowance_____

The information below may not be completed by the supplier or anyone in a financial relationship with the supplier.

Circle **Y** for Yes, **N** for No, **D** for Does not apply, unless otherwise noted.

Y N D	1)	Does the patient have multiple stage II pressure ulcers on the trunk or pelvis?
Y N D	2)	Has the patient been on a comprehensive ulcer treatment program for at least the past month which has included the use of an alternating pressure or low air loss overlay which is less than 3.5 inches, or a nonpowered pressure reducing overlay or mattress?
1 2 3	3)	Over the past month, the patient's ulcer(s) has/have: 1) Improved 2) Remained the same 3) Worsened?
Y N D	4)	Does the patient have large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis?
Y N D	5)	Has the patient had a recent (within the past 60 days) myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis? If yes, give date of surgery:
Y N D	6)	Was the patient on an alternating pressure or low air loss mattress or bed or an air fluidized bed immeadiately prior to a recent (within the past 30 days) discharge from a hospital or nursing facility?

Estimated length of need (# of months): _____(99=lifetime)

Physician name (printed or typed): _____

Physician signature: _____

Physician UPIN: _____

Date signed: _____