STATEMENT OF ORDERING PHSYCIAN
(GROUP 1 SUPPORT SURFACE)

Colonial medical supplies
614 E Altamonte Dr
Altamonte Springs, FL 32701
Phone: 407-849-6455
Fax: 407-849-6458

EFFECTIVE DATE: ___/___/_____

Patient Information:

Name: _____

Address: _____

City/State/Zip: _____

Phone: (____) _____ **DOB:** _____

Physician Information:

Name: _____

Address: _____

City/State/Zip: _____

Phone: (_____) _____ **Fax:** (____) _____

NPI: _____ **License #:** _____

All Sections must be completed. Please sign and date any changes you make to this information.

DIAGNOSIS INFORMATION

Please check all pertinent diagnoses

_____ Decubitus Ulcer, Upper Back	707.02
_____ Decubitus Ulcer, Lower Back	707.03
_____ Decubitus Ulcer, Hip	707.04
_____ Decubitus Ulcer, Buttock	707.05
_____ Decubitus Ulcer, Other Site	707.09
_____ Incontinence of feces	787.6
_____ Urinary Incontinence	788.30
_____ Venous insufficiency	459.81
_____ Parkinson's Disease	332
_____ Diabetes with neurological manifest	250.60
_____ Cachexia	799.4
_____ Disturbances of sensation of smell and taste	707.09
_____ Other (specify code) __ __ __ . __ __	

Length of need: _____ **Months (99 = lifetime)**

Prognosis: ____ **Good** ____ **Fair** ____ **Poor**

Wt. _____**lbs.** **Ht.** _____**in.**

Ulcer Location	Stage of Ulcer	Diameter

(Please check mark all that apply)

❒ **I certify the patient's medical records reflect that the patient has a care plan that includes the following:**

- Education of patient and caregiver on prevention and/or management of pressure ulcers
- Regular assessment by a nurse, physician, or other licensed healthcare practitioner
- Appropriate turning and positioning
- Appropriate wound care (for a stage II, III, or IV ulcer)
- Appropriate management of moisture/incontinence
- Nutritional assessment and intervention consistent with overall plan of care.

I certify the patient's medical records support one of the following :

❒ Patient is **completely immobile** and cannot independently make changes in body position significant enough to alleviate pressure.

❒ Patient has **limited mobility** and cannot independently make changes in body position significant enough to alleviate pressure.

ADDITIONAL COMMENTS:

BY SIGNING BELOW, I AUTHORIZE the use of this document as a form of medical records, and I certify that the above information is to prove medically necessity for the prescribed equipment and is not being prescribed for convenience. I will maintain an original signed copy of this order in my medical records and make it available to Medicare, their authorized agents or other insurer, if required.

X _____ _____ _____

Physician Signature *Date* *NPI*