PEORIA SPECIALTY INC.
Phone 309-693-4459 Fax 309-693-5801

PHYSICIAN ORDER – HOSPITAL BEDS

PATIENT NAME:____

PATIENT ADDRESS:____

ESTIMATED LENGTH OF NEED:____________________ (LIFETIME = 99)

DIAGNOSIS:____

____

TYPE OF BED ORDERED:

☐ **SEMI-ELECTRIC HOSPITAL BED (E0260)**
(with side rails and mattress

☐ **VARIABLE HEIGHT HOSPITAL BED (HI-LO) (E0255)**
(with side rails and mattress)

☐ **FULL-ELECTRIC HOSPITAL BED (E0265)**
(with side rails and mattress)

1. Does the patient have a medical condition which requires **positioning** of the body in ways **not feasible with an ordinary bed**? ☐ **YES** ☐ **NO**
2. Does the patient require body **positioning** in ways not feasible with an ordinary bed to **alleviate pain**? ☐ **YES** ☐ **NO**
3. Does the patient require the head of the bed to be elevated **at least 30 degrees** due to **CHF**, **COPD** or **aspiration**? ☐ **YES** ☐ **NO**
4. Does the patient require **traction equipment** that can only be attached to a hospital bed? ☐ **YES** ☐ **NO**
5. Does the patient require a **different bed height** to **transfer** to a Chair, wheelchair or to the standing position? ☐ **YES** ☐ **NO**
6. Does the patient require **frequent changes in body position and/or** have a need for **immediate changes in body position**? ☐ **YES** ☐ **NO**

Physician Name:___________________________________NPI:____________________________

Physician Address:____

Phone:___________________________

Physician Signature:____ Date:______________________