Golden Gate Medical Supply	612 S. Union Ave., Pueblo, CO, 81004 **Phone:** 719-569-7361 **Fax:** 719-696-8548

WRITTEN ORDER PRIOR TO DELIVERY AND STATEMENT OF ORDERING PHYSICIAN

GROUP 1 SUPPORT SURFACES

Patient: ____________________ **Insurance:** _________________________ **Start Date:** _______________

Address/Zip: ____

ICD-10/Diagnosis: ____

Product Ordered: ALTERNATING PRESSURE PAD/GEL OVERLAY **Retail:**

The information bellow MAY NOT be completed by the supplier or anyone in a financial relationship with the supplier: **PLEASE COMPLETE**

CHECK ALL THAT APPLY: INDICATE WHICH OF THE FOLLOWING CONDITIONS DESCRIBE THE PATIENT

1. Completely Immobile ☐ (I.E. Patient cannot make changes in body position without assistance)
   OR
2. Limited Mobility ☐ (I.E. Patient cannot independently make changes in body position significant enough to alleviate pressure)
   OR
3. Patient has one or more pressure ulcers (any stage) on the trunk or pelvis ☐

AND IF QUALIFYING UNDER #2 OR #3 ABOVE, THE PATIENT HAS ONE OR MORE OF THE FOLLOWING:

- **A.** Impaired Nutritional Status ☐
- **B.** Fecal or Urinary Incontinence ☐
- **C.** Altered Sensory Perception ☐
- **D.** Compromised Circulatory Status ☐

IF NONE ABOVE APPLY, ATTACH MEDICAL RECORD INFORMATION IDENTIFYING MEDICAL NECESSITY FOR THE ORDER IN QUESTION

ESTIMATED LENGTH OF NEED/NUMBER OF MONTHS: ___________________________________ (99=Lifetime)

Physician Name: ____ (Typed or Printed)

Address: ____

Physician NPI: __________________________________ **Physician MD#:** ______________________________

Physician Signature: ____ **Date:** ___________________________

(No stamp permitted)

3/10/2022mc