

# ORTHO-TEC MEDICAL, INC.

A QUALITY SUPPLIER OF ORTHOTICS & DME

15 Gore Road, P.O. Box 364, Webster, MA 01570

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## Group 2 Support Surface Prescription Form

*Prescriber Attestation may not be completed or corrected by the supplier. PRESCRIBER MUST COMPLETE, SIGN & DATE.*

Patient Name: (last) \_\_\_\_\_ (first) \_\_\_\_\_ (mi) \_\_\_\_\_

Patient Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Patient Phone: \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Insurance: \_\_\_\_\_

Prescriber's Name (printed): \_\_\_\_\_ NPI: \_\_\_\_\_

Prescriber's Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Prescriber's Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Product Ordered: Group II Support Surface (E0277)

For Treatment of (ICD-9 or narrative): \_\_\_\_\_

Start Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Length of Need (in months, 99-lifetime): \_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

*May not be completed by the supplier or anyone in a financial relationship with the supplier. Complete item 1 or 2 or 3 as applicable.*

Circle Y for Yes and N for No, or N/A for Not Applicable, unless otherwise noted.

1. Y N N/A Does the patient have multiple stage II decubitus ulcers on the trunk or pelvis?  
Y N N/A Has the patient been on a comprehensive ulcer treatment program for at least the past month, that included the use of alternating pressure or low air loss overlay which is less than 3.5 inches, or a non-powered pressure reducing overlay or mattress?

Over the past month, the patient's decubitus ulcer(s) has/have (circle one):

1) improved 2) remained the same 3) worsened

2. Y N N/A Does the patient have large or multiple stage III or IV decubitus ulcers on the trunk or pelvis?  
3. Y N N/A Has the patient had a recent (within the past 60 days) myocutaneous flap or skin graft for a decubitus ulcer on the trunk or pelvis? If so, give date of surgery: \_\_\_\_ / \_\_\_\_ / \_\_\_\_.  
Y N N/A Was the patient on an alternating pressure or low air loss mattress or bed or an air fluidized bed immediately prior to a recent (within the past 30 days) discharge from a hospital or nursing facility?

### Wound Information:

Wound # 1: Stage \_\_\_\_\_ Site: \_\_\_\_\_

Measurement Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Measurements: (L) \_\_\_\_\_ cm (W) \_\_\_\_\_ cm (D) \_\_\_\_\_ cm

Tunnels: \_\_\_\_\_ cm @ \_\_\_\_\_ o'clock

Undermining: \_\_\_\_\_ cm @ \_\_\_\_\_ o'clock

Wound # 2: Stage \_\_\_\_\_ Site: \_\_\_\_\_

Measurement Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Measurements: (L) \_\_\_\_\_ cm (W) \_\_\_\_\_ cm (D) \_\_\_\_\_ cm

Tunnels: \_\_\_\_\_ cm @ \_\_\_\_\_ o'clock

Undermining: \_\_\_\_\_ cm @ \_\_\_\_\_ o'clock

### Form completed by:

Name: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Phone: \_\_\_\_\_ Organization: \_\_\_\_\_