ORTHO-TEC MEDICAL, INC.

A QUALITY SUPPLIER OF ORTHOTICS & DME
15 Gore Road, P.O. Box 364, Webster, MA 01570
Office (888) 616-9811 or (508) 943-4433 Fax (888) 616-9812 or (508) 943-4435

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: _____

Please fax this completed form to 1-888-616-9812. Please file the original in the patient record. 7/10