ABSOLUTE MEDICAL EQUIPMENT, INC.

Group One Support Surface

Please select:

- ☐ A.P.P
- ☐ Gel Overlay
- ☐ Pressure Relieving Mattress

Date of Order:____________________

Patient Name:____________________ D.O.B.____________________

Address: ____________________

____

Phone: ____________________ Alt Phone: ____________________

A patient must meet the following requirements to qualify for this equipment:

Either A) Criterion 1

OR

B) Criteria 2 or 3 AND at least one of criteria 4-7

____
diagnosis code

____
length of need
99 = lifetime

Please select matching criteria:

- ☐ 1. Completely immobile - i.e., patient cannot make changes in body position without assistance
- ☐ 2. Limited mobilty - i.e., patient cannot independently make changes in body position significant enough to alleviate pressure
- ☐ 3. Any stage pressure ulcer on trunk or pelvis
- ☐ 4. Impaired nutritional status
- ☐ 5. Fecal or urinary incontinence
- ☐ 6. Altered sensory perception
- ☐ 7. Compromised circulatory status

Physicians Name: ____________________

Address:____________________

Phone:____________________ NPI:____________________

X____________________ Date____________________
Physician Signature

560 Marksmen Court
Fayetteville, Georgia 30214
770-716-3833
770-716-3834 fax

30 East Gordon Road
Newnan, Georgia 30263
678-854-9234
678-854-9238 fax

6014 Macon Road
Columbus, Georgia 31907
706-562-1600
706-562-1909 fax