DOME HOME CARE
24 15TH STREET SUITE # 205
BROOKLYN, NY 11215

DURABLE MEDICAL EQUIPMENT STATEMENT OF ORDERING PHYSICIAN
WRITTEN ORDER PRIOR TO DELIVERY

Beneficiary Name: DOB: Effective Date:
Address: HICN:
City, State, Zip: WT:_____

DIAGNOSIS (ES): _____ _____ _____ Last Seen On:_____

PROGNOSIS (CHECK ONE): ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐ GUARDED

HCPCS CODE	ITEM DESCRIPTION	QTY
E0277	Low Air Loss Mattress	1

THE ABOVE IS MEDICALLY NECESSARY BECAUSE: (Y = Yes / N = No / D = Does Not Apply)

THE FOLLOWING PRESSURE ULCERS PROGRESS MUST BE UPDATED EVERY 3 MONTHS FOR CONTINUED INSURANCE COVERAGE ELIGIBILITY. MUST SUBMIT SUPPORTING CHART NOTE DOCUMENTATION.

Y N D 1) Does the patient have multiple stage II or III or IV pressure ulcers on the trunk or pelvis?

NUMBER OF WOUNDS _____ TIMES/DAILY DRESSING CHANGED _____

#1. DEPTH_____CM	#2. DEPTH _____CM	#3. DEPTH _____CM
WIDTH _____CM	WIDTH _____CM	WIDTH _____CM
STAGE _____	STAGE _____	STAGE _____
LOCATION _____	LOCATION _____	LOCATION _____

Y N D 2) Has the patient been on a comprehensive ulcer treatment program for at least the past month which has included the use of an alternating pressure or low air loss overlay which is less than 3.5 inches, or a nonpowered pressure reducing overlay or mattress?

1 2 3 3) Over the past month, the patient's ulcer(s) has/have: 1) Improved 2) Remained the same or 3) Worsened?

Y N D 4) Does the patient have large or multiple stage III or IV pressure ulcer(s) on the trunk or pelvis?

Y N D 5) Has the patient had a recent (within the past 60 days) myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis? If yes, give date of surgery: _____/_____/_____

Y N D 6) 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?

PHYSICIAN NAME: NYS LIC:
ADDRESS: NPI:
CITY, STATE, ZIP:

PHYSICIAN SIGNATURE _____ DATE_____ / _____ / _____

***NOTE TO PHYSICIAN:** BY SIGNING THIS FORM YOU ARE CERTIFYING THAT YOU HAVE SUPPORTING DOCUMENTATION VERIFYING THIS INFORMATION IN THE PATIENTS PERMANENT MEDICAL RECORDS & THE DOCUMENTATION WILL BE AVAILABLE UPON REQUEST.