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NSC#: 4200880001

Client Name: _____ **Client ID:** _____

Medicare Group 1 Mattress Overlay Questionnaire

Please answer the following 4 questions and provide any additional chart notes.

1) Is the patient completely immobile – i.e., patient cannot make changes in body position without assistance, **or**

_____

2) Does the patient has limited mobility – i.e., patient cannot independently make changes in body position significant enough to alleviate pressure **and** at least one of the conditions A-D below, **or**

_____

3) Does the patient has any stage pressure ulcer on the trunk or pelvis **and** at least one of the conditions A-D below.

_____

4) Does the client have any of the conditions for criteria 2 and 3 (in each case the medical record must document the severity of the condition sufficiently to demonstrate the medical necessity for a pressure reducing support surface) Must have at least one of the following to qualify)

please circle all that applies

A. Impaired nutritional status

B. Fecal or urinary incontinence

C. Altered sensory perception

D. Compromised circulatory status

Name of person answering questions, if other then physician:

Print Name: _____ Title: _____

Signature: _____ Employer: _____

Physicians Signature: _____ Date: _____