

Title XIX

HOSPITAL BEDS	Client's Name: _____	
Client's HT: _____	WT: _____	DX: _____
Client's Medical Needs: _____ _____		
Client's condition and functional level: _____ _____		
Growth potential of equipment: _____ _____		
Necessity of Hospital bed versus current bed: _____ _____		
Necessity of manual bed versus electric bed: _____ _____		
Accurate diagnostic information pertaining to the underlying medical diagnosis/condition. Gastrostomy Feeding: ___ Suctioning: ___ Ventilator dependent: ___ Other Respiratory Equipment: ___		
Include client's overall health status: _____ _____		
Client functional mobility status: _____ _____		
Client use of any pressure-reducing support surfaces, if applicable: _____ _____		
Manufacturers product information and M.S.R.P. Model: _____ Manufacturer: _____ M.S.R.P- _____		

Pediatric Hospital Crib/Enclosed Bed
Dx: _____ AGE: _____ HT: _____ WT: _____
Clients Medical Needs: _____ _____ _____
Clients Developmental Level and Functioning Skills: _____ _____ _____
Description of any other less restrictive devices that have been used, the length of time used and way ineffective: _____ _____ _____
Why a regular child's crib, regular bed, or std. hospital bed will not meet child's needs: _____ _____ _____
Name of manufacturer and manufacturers suggested retail price: _____
The protective crib top/bubble top may also be considered for reimbursement when protective crib top/bubble top is for safety use and will not be considered when it is to be used as a restraint or for the convenience of family or care giving. If applicable, please explain. _____ _____ _____