Washington State Health Care Authority

Durable Medical Equipment (DME) Program Management Unit
PO Box 45535
Olympia, WA 98504-5535
Fax: 1-866-668-1214

Hospital Bed Evaluation

NOTE: Do **not** alter this form in any way. This form may be completed **only** by a qualified provider acting within the scope of your practice as required by WAC 182-543-0500(2) (d). You must complete all spaces. This form is required in addition to a prescription.

SECTION I

Client name	Client ID	Date of request

What is the diagnosis/medical condition requiring the use of a hospital bed? (Do not use ICD9 codes for the diagnosis.)

Length of need in months or years	Hours per day client is in bed	Hours per day a caregiver is in attendance	Hours per day client utilizes a wheelchair

SECTION II

Hospital bed requested: ☐ Manual ☐ Semi-electric ☐ Heavy duty

Does the client require the head of the bed to be elevated greater than 30 degrees for more than 50 percent of the time due to a respiratory condition? ☐ Yes ☐ No
If yes, please describe the type and severity of the respiratory condition.

Have pillows, bolsters, foam wedges, or rolled-up towels been tried? ☐ Yes ☐ No
What were the outcomes, and if not successful, why?

Why would a manual hospital bed not meet the client's needs?

Does the client require immediate (emergent) position change? ☐ Yes ☐ No
If yes, please explain.

Is the client at risk for aspiration? ☐ Yes ☐ No
If yes, what is the cause and frequency?

Is client tube-fed? ☐ Yes ☐ No	Is client on oxygen? ☐ Yes ☐ No If yes, continuous or intermittent?

Does the client require Trendelenburg position? ☐ Yes ☐ No
If yes, please explain.

For heavy-duty hospital bed: What is the client's weight? _____
If the client is under 420 lbs., what is the measurement from side to side at the widest part of the body? _____

SECTION III

Additional comments:

SECTION IV

Physician's name (print)

Physician's telephone	Physician's FAX
Physician's signature	Date