## QUESTIONNAIRE #2
### PRESSURE RELIEF MATTRESS

<table>
<thead>
<tr>
<th>Client Name:</th>
<th>Colorado Medicaid ID #:</th>
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<tbody>
<tr>
<td>Length of Need:</td>
<td>Height:</td>
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<tr>
<td>End Date:</td>
<td>Weight:</td>
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The information requested below is required to determine medical necessity. After you have completed this form, attach it to the completed Prior Authorization Request (PAR).

1) **What is the complete diagnosis with complicating factors?**

2) **Does the patient currently have any pressure sores?**
   - State location and give a complete description which includes risk factors, eg. Braden scale risk assessment score, multiple stage II on trunk or pelvis or any stage III or IV?
   - Yes [ ] No [ ]

3) **Is the patient presently on a pressure-relief system or been on an ulcer treatment program that has included the use of a non powered pressure reducing overlay/mattress or alternating pressure pad?**
   - Yes [ ] No [ ]
   - Pressure –Relief System [ ] Ulcer Treatment Program [ ]

4) **What past and current equipment has been trailed/ utilized?**

5) **Why isn't the current equipment (if any) meeting the client's needs?**

6) **What type of mattress does the client require based on the client's past and present skin condition history?**
   a) Describe which group mattress is required based on the above information.

7) **Explain in detail the client's ability to stand, ambulate, transfer and change positions.**

8) **How many hours per day is this client in bed?**

9) **If this client has a history of skin breakdown, please explain?**

10) **Has there been any surgical intervention?**
    - Yes [ ] No [ ]

11) **Has client's nutritional status been assessed?**
    - Explain.

12) **Please supply any additional information that will assist us in determining **medical necessity** for this request:**

Print Prescriber Name: __________________________

Prescriber Signature: ____________________________ Date: ________________

Revision Date: 09/15