BLACKBURN'S
HAR-KEL INC. Medical Specialties
a division of BLACKBURN'S

Group 3 (Air Fluidized Therapy Bed L33692-E0194) Certification Form

Please complete all the information below and attach all patient demographic information

Phone: 800-472-2440 Fax: 724-230-3705

Please contact Customer Service with any questions

PATIENT

First Name: _____ Last Name: _____ Male: ☐ Female: ☐

Address: _____ DOB: _____ HGT: _____ WGT: _____

City: _____ State: ___ Zip: _____ Phone: _____ Alternate Phone: _____

Email: _____ Patient's Preferred Language: ☐ English ☐ Spanish Other: _____

Responsible / Emergency Contact: _____ Phone: _____

Is the patient being seen by a Home Health Agency? ☐ Yes ☐ No Has the patient been notified of this order? ☐ Yes ☐ No

INS

Primary Insurance: _____ Policy ID # _____ Group #_____ Phone: _____

Secondary Insurance: _____ Policy ID # _____ Group #_____ Phone: _____

Section I: WOUND ASSESSMENT (Please attach chart notes that include detailed wound information)

Wound	Type	Location	Length X Width	Depth	Tunnelling	Drainage Amount / Color	Wound Color	Odor (Yes / No)
1.	_____	_____	_____cm X _____cm	_____cm	_____cm	_____ / _____	_____	_____
2.	_____	_____	_____cm X _____cm	_____cm	_____cm	_____ / _____	_____	_____
3.	_____	_____	_____cm X _____cm	_____cm	_____cm	_____ / _____	_____	_____
4.	_____	_____	_____cm X _____cm	_____cm	_____cm	_____ / _____	_____	_____

Section II: TREATMENT INFORMATION (Please attach chart notes that include detailed treatment information)

1. Is the patient bed or chair bound at least 18 hours per day? ____
2. In the absence of this equipment, would institutionalization be required? ____
3. Is the continued use of the air fluidized bed medically necessary for wound management? ____
4. Is the patient incontinent? ____
5. Is a turning/repositioning schedule in place and being followed? ___ If the patient cannot be turned/repositioned, explain contraindications: _____
6. Is the patient assessed at least weekly by a clinician? ____
7. Is the patient's current nutritional status sufficient for wound healing? ____
8. Describe the patient's current nutritional status. Indicate the type / frequency of nutritional supplement or support being provided: _____
9. Is a clean, moist bed of granulation tissue with moist dressings being maintained? ____
   If NO, specify excluding-dressing wound characteristics: _____
10. Have necessary treatments been provided to resolve any wound infections? ___
11. Is a trained adult caregiver available to assist the patient? ____
12. Has any wound improvement occurred within the previous 30 days? ____
    If not, fully describe contributing factors and changes made to the patient's plan of care: _____

** **Select Type of Bed Rails (pick one)** ☐ Assist Rails ☐ Half Rails ☐ Full Rails ☐ No Rails

Section III: CLINICIAN / REFERRAL INFORMATION

Facility / Office Name: _____ Phone: _____

Address: _____ Fax: _____

Name of Clinician completing monthly wound tracking records (attached): _____

Email: _____

How would you prefer to be contacted: ☐ Phone ☐ Fax ☐ Email

BY SIGNING BELOW, I CERTIFY that I am the clinician identi ied in this section and AUTHORIZE the use of this document as an order. I certify that the above prescribed supplies are medically necessary and reasonable. I will maintain an orginal signed and dated copy of this order in my medical records.

Ordering Clinician or Licensed Presciber: (Please Print - Stamps not permitted) _____

Signature: _____ Date: _____ MD# _____ NPI: _____

LENGTH NEEDED: ☐ 3 Months ☐ Other: _____