State of Illinois
Department of Healthcare and Family Services

Air Fluidized Bed Questionnaire

Patient Name: _____ DOB: _____ RIN: _____

Answers to all of the questions are required for prior approval requests for air fluidized beds. **Updated information must be submitted for additional months of rental following the initially approved rental including a current Wound Measurement Assessment Form.**

1. Provide complete list of primary and secondary diagnoses as well as comorbidities and complicating factors including but not limited to chemotherapy, transplant recipient, dementia, obesity, nutritional deficiencies, mobility limitations, impaired sensation, hip or knee replacement, fracture, lack of compliance, osteomyelitis, peripheral vascular disease, venous insufficiency, tobaccoism, diabetes mellitus, and caregiver health impairments/ competency. Please indicate if the condition is permanent.

2. Provide description of any wounds by completing the Wound Measurement Assessment Form. This assessment must be no more than 7 days old at the time of receipt of the prior approval request.

3. Height _____ Weight _____

4. Does the patient have a caregiver available? Yes ☐ No ☐

   If yes, indicate number of hours per day of availability: _____

5. Is the patient left alone for long periods of time? Yes ☐ No ☐

   If yes, how many hours maximum at a given time? _____

6. Is the patient ambulatory? Yes ☐ No ☐

   Is the patient bedridden? Yes ☐ No ☐

   If yes, what is the transfer method? _____

7. Does the patient have sufficient upper body strength and capability to reposition self? Yes ☐ No ☐

8. Is the patient able to operate the controls on the proposed bed? Yes ☐ No ☐

9. Has the patient been on a pressure-relief system or on an ulcer treatment program for at least the last month that has included the use of a non-powered pressure-reducing overlay/mattress or alternating pressure pad?

   Yes ☐ No ☐

If yes, describe further:

10. Does the patient require positioning not feasible in a standard bed due to a medical condition expected to last at least 1 month? Yes ☐ No ☐

If yes, please explain: _____

11. Does the patient require special positioning for the relief of pain not feasible with an ordinary hospital bed? Yes ☐ No ☐

12. Does the patient require a bed height different than a fixed height hospital bed to permit transfers? Yes ☐ No ☐

13. Provide details of past and present wound treatment plan that include but are not limited to the following as relevant:

a. Education of patient and caregivers for turning and repositioning
b. Management of nutritional deficiencies
c. Treatment of anemia
d. Incontinence management
e. Measures to offload pressure and reduce risk of shear (sheepskin pads, air flotation powered bed, gel pressure mattress, pressure pads for mattress, powered pressure reducing air mattress, or powered pressure reducing mattress overlay).
f. Improvement of glucose control for diabetics
g. Treatment of infected wound and/or osteomyelitis
h. Topical antimicrobials
i. Growth factors, skin substitutes, electromagnetic therapy, electrical stimulation, hyperbaric oxygen, thermal ultrasound, topical collagen, and extracellular matrix protein
j. Compression for venous insufficiency
k. Revascularization for arterial insufficiency
l. Surgical intervention (flap, graft - provide date of surgery)
m. Debridement (surgical, enzymatic)
n. Negative pressure wound therapy
o. Noncontact low frequency low intensity ultrasound delivered through saline mist or autologous activated platelet rich plasma

_____ _____

Practitioner's Signature with degree: Date

Office Phone #: _____ Fax: _____ NPI: _____