State of Illinois
Department of Healthcare and Family Services

HOSPITAL BED QUESTIONNAIRE

PATIENT INFORMATION

Name: ______________________ Recipient ID: ______________________

Diagnosis: ______________________ Height: ______________ Weight: ______________

☐ Semi-Electric Hospital Bed ☐ Full Electric Hospital Bed

Does the patient have a caregiver? ☐ Yes ☐ No

Is the patient left alone for long periods of time? ☐ Yes ☐ No
If yes, how many hours per day? ______________________

Can the patient ambulate? ☐ Yes ☐ No

Is the patient bedridden? ☐ Yes ☐ No
If bedridden, what is the transfer method? ______________________

Is condition permanent? ☐ Yes ☐ No
If no, what is duration of need? ______________________

Can patient reposition self? ☐ Yes ☐ No

Is the patient able to operate controls on the hospital bed? ☐ Yes ☐ No

Does the patient require positioning not feasible in a standard bed? ☐ Yes ☐ No
If yes, explain: ______________________

Is this for post-op use? ☐ Yes ☐ No
If yes, date of surgery: ______________________

Prognosis: ______________________

Physician's signature: ______________________ Date: ______________