State of Louisiana – DHH - Medicaid
Pediatric Hospital Bed Evaluation

Instructions:

1. PA-01 and Pediatric Hospital Bed Evaluation form are required with all requests.
2. Writing must be legible.
3. All sections must be completed by the professional listed and initialed. Enter N/A for items/sections that do not apply.
4. Please attach Physician prescription and original manufacturer invoice sheets.
   Glossary of terms is on the last page of form

I. GENERAL INFORMATION (PROVIDER): _____ Initials

Date of Evaluation: _____
Recipient Name: _____ DOB: _____
Recipient's Address: _____
Recipient's Height: _____ Recipient's Weight: _____
Medicaid ID #: _____ Other Insurance: _____
Physician Name: _____ Therapist Name: _____

II. MEDICAL HISTORY (PHYSICIAN): _____ Initials

Diagnosis: _____
Age at diagnosis: _____ Prognosis: _____
Summary of medical condition to warrant a pediatric hospital bed: _____
_____
_____
_____
_____
_____
_____
Estimated length of need for pediatric hospital bed: _____

III. PRESENT PEDIATRIC HOSPITAL BED (PROVIDER): _____ Initials

Does the recipient currently own any type of hospital bed: ☐ Yes ☐ No
If yes, please provide the following information:
Serial #: _____ Age: _____
Model: _____ Size: _____
Price: _____ Funding Source: _____
Can the hospital bed be repaired? ☐ Yes ☐ No
If yes, please explain.
_____
_____
_____
_____
Why is the current hospital bed not meeting the recipient's needs:
_____
_____

_____
_____

IV. HOME ENVIRONMENT (PROVIDER/THERAPIST): _____ Initials

□ Home □ Apartment □ Mobile Home □ Asst. Living
□ Alone □ With family/caregivers
Is the caregiver available 24 hours a day? □ Yes □ No
If no, how many hours a day is the caregiver available? _____
Will the home environment accommodate the recommended pediatric hospital bed? □ Yes □ No
If no, will the home be modified? □ Yes □ No
Comments: _____
_____
_____
_____

V. COGNITION (THERAPIST): _____ Initials

Memory □ Intact □ Impaired Comments: _____
Problem Solving □ Intact □ Impaired Comments: _____
Attn/Concentration □ Intact □ Impaired Comments: _____
Vision □ Intact □ Impaired Comments: _____
Hearing □ Intact □ Impaired Comments: _____
Judgment □ Intact □ Impaired Comments: _____

VI. COMMUNICATION (THERAPIST): _____ Initials

□ Verbal □ Non Verbal □ Sign Language □ Gestures □ Communication Device

VII. SENSATION (THERAPIST): _____ Initials

□ Intact □ Impaired □ Absent
History of pressure sores? □ Yes □ No
If yes, provide location and stage: _____
Current pressure sores? □ Yes □ No
If yes, provide location and stage: _____
Bowel management: □ Continent □ Incontinent
Bladder management: □ Continent □ Incontinent

VIII. PATHOLOGICAL REFLEXES (THERAPIST): _____ Initials

□ Asymmetrical tonic neck reflex □ Symmetrical tonic neck reflex □ Tonic labyrinthine reflex supine
□ Tonic labyrinthine reflex prone □ Extensor tone □ Startle □ Positive Supporting
□ Other: _____
Comments: _____
_____
_____

IX. MOBILITY (THERAPIST): _____ Initials

Bed Mobility: □ Independent □ Mod I □ SPV □ Min A □ Mod A □ Max A □ Dependent
Transfers: □ Independent □ Mod I □ SPV □ Min A □ Mod A □ Max A □ Dependent

Method: □ Stand Pivot □ Squat Pivot □ Scoot Pivot □ Sliding Board □ Lift

Ambulatory status: □ Independent □ Mod I □ SPV □ Min A □ Mod A □ Max A □ Dependent □ Non-ambulatory

Distance: □ < 25 feet □ 25 – 50 feet □ 50- 100 feet □ 100-150 feet □ >150 feet

Device: □ Straight Cane □ Quad Cane □ Crutches □ Forearm Crutches □ Walker □ Gait Trainer □ None □ Other: _____

Wheelchair mobility: □ Independent □ Mod I □ SPV □ Min A □ Mod A □ Max A □ Dependent

X. PEDIATRIC HOSPITAL BED TRIAL & CONSIDERATIONS (THERAPIST/PROVIDER):

_____ ***Initials***

Does the recipient have seizures? □ Yes □ No

If yes, please provide how often seizures occur with medications. _____

Is the desired medical benefit attainable by the use of an ordinary bed? □ Yes □ No

If no, please explain: _____

_____

_____

_____

Can an ordinary bed be modified or adapted by commercially available items to meet the medical needs?

□ Yes □ No

If no, please explain: _____

_____

_____

_____

Please document how the child's current bed has failed to protect the recipient. _____

_____

_____

_____

Does the recipient have a medical condition that is expected to last greater than 6 months which requires positioning of the body in ways that are not feasible with an ordinary bed or hospital bed?

□ Yes □ No

Does the recipient require the head of the bed to be elevated more than 30 degrees due to a medical condition or documented problems with aspiration? □ Yes □ No

Have pillows or wedges been considered and ruled out? □ Yes □ No

Does the recipient have a history of behavior involving unsafe mobility (ex: climbing out of bed)?

□ Yes □ No

If yes, please explain: _____

_____

_____

_____

_____

Does the recipient have any documented injuries while in an ordinary bed or standard hospital bed?

□ Yes □ No

If yes, please explain: _____

_____

_____

_____

Please document whether all least costly alternatives were tried and unsuccessful. Please provide comments on why each item was unsuccessful:

- rail protectors □ Yes □ No _____
  _____
- putting a mattress on the floor □ Yes □ No _____
  _____
- medications to address seizures and/or behaviors □ Yes □ No _____
  _____
- helmets for head banging □ Yes □ No _____
  _____
- removing safety hazards from the recipient's room/child protection devices – on door knob, baby gate to prevent child from leaving room □ Yes □ No _____
  _____
- baby monitors and bed alarm systems □ Yes □ No _____
  _____
- behavior modification strategies □ Yes □ No _____
  _____
- ruled out physical and environmental factors for behavior – hunger, thirst, toileting, pain, restlessness, fatigue due to sleep deprivation, acute physical illness, temperature, noise levels, lighting, medication side effects, over- under stimulation, or a change in caregivers or routine. □ Yes □ No _____
  _____
- patient would be institutionalized without the bed □ Yes □ No

Comments:_____
_____
_____
_____
_____

XI. POSTURE (THERAPIST): (note if assessment done in sitting or supine) _____ Initials

Head Posture: □ WFL □ Flexed □ Extended □ Rotated □ Laterally flexed □ Cervical hyperextension
Head Control: □ Normal □ Good □ Fair □ Poor □ Absent
Trunk Posture: □ WFL □ Thoracic kyphosis □ Lumbar lordosis □ Scoliosis: left or right C or S curve
□ Rotation: left or right
Trunk Tone: □ Hypotonia □ Normal □ Hypertonia □ Spasticity □ Rigidity □ Athetosis □ Ataxia
□ Tremors
Severity: □ Mild □ Moderate □ Severe
Pelvis: □ Neutral □ Posterior □ Anterior □ Obliquity: left or right □ Rotation: left or right
□ Windswept: left or right □ Subluxation □ Dislocation □ Fracture

XII. UPPER EXTREMITY (THERAPIST): _____ Initials

General UE ROM and Strength: _____
_____

Shoulders:

- □ WFL
- □ Elevated/Depressed □ Fixed □ Partially flexible □ Flexible
- □ Protracted/Retracted □ Fixed □ Partially flexible □ Flexible
- □ Subluxed

Hands:

□ WFL □ Fisting □ Other: _____

UE Tone: □ Flaccid □ Hypotonia □ Normal □ Hypertonia □ Spasticity □ Rigidity

Comments on the recipient's UE: _____

_____

_____

XIII. LOWER EXTREMITY (THERAPIST): _____ Initials

General LE ROM and Strength: _____

_____

Hip position:

□ Neutral □ Hip Abduction □ Hip Adduction □ Subluxed □ Dislocated □ Leg length discrepancy

□ Fixed □ Partially fixed □ Flexible

Windswept:

□ Neutral □ Right □ Left

□ Fixed □ Partially fixed □ Flexible

Does the recipient wear AFO's? □ Yes □ No

LE Tone: □ Flaccid □ Hypotonia □Normal □Hypertonia □ Spasticity □ Rigidity

Comments on recipient's LE: _____

_____

_____

XIV. BALANCE (THERAPIST): _____ Initials

Sitting Balance:

Static: □ Normal □ Good □ Fair □Poor □Absent

Dynamic: □Normal □Good □Fair □Poor □Absent

Standing Balance:

Static: □ Normal □ Good □Fair □Poor □Absent

Dynamic: □ Normal □Good □Fair □Poor □Absent

Comments: _____

_____

XV. PAIN AND EDEMA (THERAPIST): _____ Initials

Pain: □ Yes □ No

If yes, please state, severity (using the visual analog scale 0-10), location, and how often (daily, weekly, monthly). _____

_____

Is the recipient on pain medication? □ Yes □ No

If yes, please list medication. _____

Does pain medication alleviate the recipient's pain? _____

Edema: □ Yes □ No

If yes, please state severity, location, and how often (daily, weekly, monthly). _____

_____

XVII. RECOMMENDED PEDIATRIC HOSPITAL BED & NON-STANDARD PARTS (THERAPIST/PROVIDER): _____ Initials

1. Please provide the original manufacturer invoice.
2. Please describe the medical necessity for the requested equipment.
3. Please justify the pediatric hospital bed size being recommended.
4. Medically justify each non-standard part on the pediatric hospital bed.
5. List the pediatric hospital bed parts in order of the manufacture price sheet.
6. Stamp signatures are not accepted.
7. The provider can assist with all pediatric hospital bed part justifications.

Pediatric Hospital Bed Model: _____
Justification: _____
_____
_____
_____

Pediatric Hospital Bed size requested: _____
Justification: _____
_____
_____
_____

Non-standard part on Pediatric Hospital Bed: _____
Justification: _____
_____
_____
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Non-standard part on Pediatric Hospital Bed: _____
Justification: _____
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Non-standard part on Pediatric Hospital Bed: _____
Justification: _____
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Non-standard part on Pediatric Hospital Bed: _____
Justification: _____
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_____ ***Initials***

Non-standard part on Pediatric Hospital Bed: _____
Justification: _____
_____
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Non-standard part on Pediatric Hospital Bed: _____
Justification: _____
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Non-standard part on Pediatric Hospital Bed: _____
Justification: _____
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Non-standard part on Pediatric Hospital Bed: _____
Justification: _____
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Non-standard part on Pediatric Hospital Bed: _____
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Non-standard part on Pediatric Hospital Bed: _____
Justification: _____
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Non-standard part on Pediatric Hospital Bed: _____
Justification: _____
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_____ ***Initials***

Non-standard part on Pediatric Hospital Bed: _____
Justification: _____
_____
_____
_____

Non-standard part on Pediatric Hospital Bed: _____
Justification: _____
_____
_____
_____

Therapist Signature:

I, _____ was present and participated in this evaluation, have personally completed this evaluation, and agree that the above Pediatric Hospital Bed and all the non-standard parts recommended are medically necessary for the above patient.

Physician Signature:

I, _____, have read this evaluation and agree that the above Pediatric Hospital Bed and all the non-standard parts recommended are medically necessary for the above patient.

_____
Therapist (Print Name)

_____ _____
Therapist's Signature/Credentials Date

_____
Physician (Print Name)

_____ _____
Physician's Signature/Credentials Date

_____
Provider (Print Name)

_____ _____
Provider's Signature/Credentials Date

Glossary of Terminology:

Abd – abduction
Add – adduction
AFO – ankle foot orthosis
AROM – active range of motion
Asst – assistive
Attn – attention
DF – dorsi-flexion
DOB – date of birth
ER – external rotation
EV – eversion
Ext – extension
Flex – flexion
IR – internal rotation
IV – inversion
Lbs – pounds
LE – lower extremity
Max A – maximal assistance
Min A – minimal assistance
MMT – manual muscle testing
Mod A – moderate assistance
Mod I – modified independent
N/A – not applicable
PF – planter-flexion
PROM – passive range of motion
ROM – range of motion
SPV – supervision
UE - upper extremity
WFL – within functional limits