

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

Please contact Customer Service with any questions

<b>First Name:</b>	<b>Last Name:</b>	<b>Male:</b>	<b>Female:</b>
<b>Address:</b>	<b>DOB:</b>	<b>HGT:</b>	<b>WGT:</b>
<b>City:</b>	<b>State:</b>	<b>Zip:</b>	<b>Phone:</b>
<b>Email:</b>	<b>Patient's Preferred Language:</b> English Spanish Other:		
<b>Responsible / Emergency Contact:</b>		<b>Phone:</b>	
Is the patient being seen by a Home Health Agency? Yes No			
Has the patient been notified of this order? <input type="checkbox"/> Yes <input type="checkbox"/> No			

<b>Primary Insurance:</b>	<b>Policy ID #</b>	<b>Group #</b>	<b>Phone:</b>
<b>Secondary Insurance:</b>	<b>Policy ID #</b>	<b>Group #</b>	<b>Phone:</b>

WOUND INFORMATION (Please include chart notes that include detailed wound information)																		
Wound	ICD-10 CODE (REQUIRED)	Location	Frequency of Change	Wound debrided?		Length x Width x Depth			Stage/Thickness				Drainage					
				Yes	No	cm	X	cm	cm	2	3	4	Partial	Full	None	Min	Mod	Hvy
1.																		
2.																		
3.																		
Additional Wound Information																		

### REQUESTED WOUND PRODUCTS (Please check the box under each wound for the appropriate dressings)

DRESSINGS:					QTY	WND #1	WND #2	WND #3	DRESSINGS:					QTY	WND #1	WND #2	WND #3
ABD Pad (1/day)	5x9	7.5x8	8x10						Foam (3/week)	2x2	4x4	4x8					
Adaptic (1/day)	3x3	3x8							Bordered Foam (3/week) <small>(size includes border)</small>	3x3	4x4	6x6					
Collagen (1/day)	2x2	4x4	Powder						Composite (3/week) <small>(size includes border)</small>	4x4	6x6						
Collagen w/ Silver (1/day)	2x2	4x4							Bordered Gauze (1/day) <small>(size includes border)</small>	4x4	6x6						
Calcium Alginate (1/day)	2x2	4x4	4x8	Rope					Roll Gauze (3/day)	2"	3"	4"					
Calcium Alginate w/ Silver (1/day)	2x2	4x4	4x8	Rope					Kerlix (3/day)	3"	4"						
Gauze (3/day)	2x2	4x4	4x8						<small>(Tape quantities: 1" - 2 / month    2" - 1 / month    4" - 1 / month)</small>								
Hydrogel	3 oz tube <small>(1 / month)</small>	2x2 pad <small>(1 / day)</small>	4x4 pad <small>(1 / day)</small>						Paper Tape	1"	2"						
Packing Strips - Plain	1/4"	1/2"	1"						Cloth Tape	1"	2"						
Packing Strips - Iodoform	1/4"	1/2"	1"						Medipore Tape	2"	4"						
Xeroform (1/day)	2x2	4x4	5x9	1x8					Other:								
Vaseline Gauze (1/day)	3x9	1x8							Other:								
									Other:								

### REFERRAL INFORMATION

<b>Office Name:</b>	<b>Phone:</b>
<b>Address:</b>	<b>Fax:</b>
<b>Contact:</b>	<b>Email:</b>
<b>How would you prefer to be contacted:</b> Phone Fax Email	

**BY SIGNING BELOW, I CERTIFY that I am the clinician identified 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 original signed and dated copy of this order in my medical records.*

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ MD# \_\_\_\_\_ NPI: \_\_\_\_\_

**PRESCRIPTION VALID FOR:** 30 Days 60 Days 90 Days # of Refills: \_\_\_\_\_ **START DATE:** \_\_\_\_\_ **DISPENSE:** 2 Week Supply 30 Day Supply