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CONTINUUM CONNECT WOUND CARE ORDER FORM

\*\*Please attach face sheet w/ patient demographics & insurance info\*\*

PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  Male  Female
Language Pref.:  English  Spanish  Other: \_\_\_\_\_ Is the patient currently using Nutritional Supplements?  YES  NO
Emergency Contact Name/Phone Number: \_\_\_\_\_

WOUND ASSESSMENT

Table with 5 columns: ICD-10 Code, Wound Location, Has the wound ever been debrided?, Length x Width x Depth, Stage/Thickness, Drainage. Rows 1, 2, 3.

PRODUCT SELECTION

Table with 5 columns: Wound Dressing, Frequency of Change, Qty, Select Wound (with X) W1, W2, W3. Lists various dressings like Collagen, Calcium Alginate, Hydrocolloid, etc.

Length of Need: \_\_\_\_\_ months
Dispense Amount (select one):  15-day  30-day
Has the patient been educated on how to apply the dressings?  YES  NO
Cleansing Products\* (Check all that apply)
Saline 100ml:  5  10  15  Other \_\_\_\_\_  Non-Sterile Gauze 4"x8" (Sleeve-200)
Gloves(1 box):  Medium  Large

REFERRAL INFORMATION

Ref #: \_\_\_\_\_

Practice Name: \_\_\_\_\_ Fax: \_\_\_\_\_
Office Address: \_\_\_\_\_ Email: \_\_\_\_\_
Phone: \_\_\_\_\_ Preferred Method of Contact?  Phone  Fax  Email
Contact Person: \_\_\_\_\_

Physician Name: \_\_\_\_\_ NPI#: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Ext. \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing below, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed. I certify that my decision to prescribe this recommended product was solely based on my determination of medical necessity set forth herein. This document may serve as a confirmation of a verbal order and is also recorded in the patient's record.

Assignment of Benefits: I request that payment of my insurance benefits be made to CHC Solutions, Inc., or any of its subsidiaries, for any supplies or services they provide me. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home cannot be returned if opened. By signing below, I authorize the distribution of my information to CHC Solutions, Inc., or any of its subsidiaries, which may be needed to determine benefits payable for these services or supplies. I authorize CHC Solutions, Inc., or any of its subsidiaries, to forward my medical records to the medical professionals in my care and/or make copies of said records.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_