Continuum
a CHC Solutions Company

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HOME HEALTH 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

WOUND ASSESSMENT

ICD-10 Code	Wound Location	Has the wound ever been debrided?	Length x Width x Depth	Stage/Thickness	Drainage
1.		☐YES ☐NO		☐ 2 ☐ 3 ☐ 4 ☐ Partial ☐ Full	☐None ☐Min ☐Mod ☐Hvy
2.		☐YES ☐NO		☐ 2 ☐ 3 ☐ 4 ☐ Partial ☐ Full	☐None ☐Min ☐Mod ☐Hvy
3.		☐YES ☐NO		☐ 2 ☐ 3 ☐ 4 ☐ Partial ☐ Full	☐None ☐Min ☐Mod ☐Hvy

WOUND CARE PRODUCT SELECTION

Wound Dressing	Qty	Select Wound (with X) W1	W2	W3	Wound Dressing	Qty	Select Wound (with X) W1	W2	W3
Collagen ☐ 2x2 ☐ 4x4 ☐ Rope					Antimicrobial Roll Gauze Sterile ☐ 2" ☐ 3" ☐ 4"				
Collagen w/ Silver ☐ 2x2					Conforming Roll Gauze ☐ 2" ☐ 3" ☐ 4"				
Calcium Alginate ☐ 2x2 ☐ 4x4.75 ☐ 4x8 ☐ Rope					Kerlix ☐ Antimicrobial 4.5" ☐ 4.5"				
Calcium Alginate w/ Silver ☐ 2x2 ☐ 4x4.75 ☐ 4x8 ☐ Rope					Gauze Pad Antimicrobial ☐ 2x2 ☐ 4x4 ☐ 6.75x6.75				
Hydrocolloid ☐ 2x2 ☐ 4x4 ☐ 6x6 ☐ Thin					Gauze Pad Sterile (2 per change) ☐ 2x2 ☐ 4x4 ☐4x8				
Hydrogel/Hydrogel Sheets ☐3oz. tube ☐2x2 ☐4x4 ☐8oz. spray					Composite Dressing ☐ 4x4 ☐ 6x6 ☐ 6x8 (size includes border)				
Foam Dressing ☐2.5x2.5 ☐3x3 ☐4x4 ☐4x5 ☐4x8 ☐6x6					Foam Dressing w/ Border ☐ 3x3 ☐ 4x4 ☐ 5x5 (size includes border)				
Foam Dressing w/ Silver ☐ 4x4 ☐ 4x5					Tape: ☐1" ☐2" ☐3" Type: _____				
ABD Pad ☐ 5x9 ☐ 8x7.5 ☐ 8x10					Medipore: ☐ 2" ☐ 4"				
Other:									

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: ☐ 4 ☐ 8 ☐ 12 ☐Other _____ ☐ Non-Sterile Gauze 4"x8" (Sleeve-200) Gloves(1 box): ☐ Medium ☐ Large

*These products are not covered by Medicare and/or Medicare Advantage Plans. If the above patient's insurance benefits follow such guidelines, then these supplies will not be shipped unless the patient agrees to purchase them.

UROLOGICAL ASSESSMENT

Primary Diagnosis- ICD-10 Code: _____ Secondary Diagnosis- ICD-10 Code: _____

UROLOGICAL PRODUCT SELECTION

INTERMITTENT CATHETERS

Type	*Size*	*Length*
☐ Straight ☐ Hydrophilic Straight	☐6FR ☐8FR ☐10FR ☐12FR ☐14FR ☐16FR ☐18FR ☐Other	☐ 6" (female) ☐ 10" (pediatric) ☐ 16" (adult)
☐ Coude **(medical records required)** ☐ Hydrophilic Coude		
☐ Closed System **(medical records required)**		
☐ Red Rubber		

☐ Intermittent Catheter Tray

MALE EXTERNAL CATHETERS

Size _____mm

Qty: _____

Lubricant: ☐ Ind. Packets ☐ Tube
Qty: _____

FOLEY CATHETER

Size

☐10cc ☐30cc
French Size: _____
Qty: _____
☐ Latex ☐ Silicone
☐ Foley Insertion Tray

☐ Leg Bag ☐ 500ml ☐ 1000ml
Qty: _____

☐ Bedside Bag ☐ 2000ml
Qty: _____

FREQUENCY PER DAY: ☐ 1x/day ☐ 2x/day ☐ 3x/day ☐ 4x/day ☐ 5x/day ☐ 6x/day ☐ Other_____ Qty: _____

UROLOGY ACCESSORIES

☐ Foley Irrigation Tray	Qty: _____	☐ Leg Strap: ☐ Medium ☐ Large	Qty: _____	☐ Tape ☐ 1" ☐ 2" ☐ 3" ☐ Plastic (waterproof) ☐ Cloth (waterproof)	Qty: _____
☐ Saline	Qty: _____	☐ AMD Split Gauze 4x4	Qty: _____	☐ Flexitrack Anchoring Device	Qty: _____
☐ Appliance cleaner	Qty: _____	☐ Split Gauze 4x4	Qty: _____	☐ Other_____	Qty: _____

OSTOMY ASSESSMENT

Primary Diagnosis ICD-10 Code: _____
**Code must state the specific type of ostomy.

Secondary Diagnosis ICD-10 Code: _____
**Code must state the specific type of ostomy.

TYPE OF OSTOMY

☐ **Colostomy** ☐ **Ileostomy** ☐ **Urostomy**

MANUFACTURER

☐ **Hollister** ☐ **Securi-T USA**

OSTOMY PRODUCT SELECTION (All Accessories are Securi-T Brand)

Check all products that apply		Qty	Product #
1 Piece Pouch	☐ Closed ☐ Drainable		
2 Piece Pouch	☐ Closed ☐ Drainable		
Wafer (for 2 Piece Pouch) Stoma Size:_____	☐ Flat ☐ Convex		
Bedside Urinary Drainage Bag	☐ One Size		
Barrier Ring	☐ 2" ☐ 4"		
Stoma Paste	☐ One Size		
Skin Prep Wipes	☐ One Size		
Barrier Strips	☐ One Size		

Check all products that apply		Qty	Product #
Deodorant	☐ 8 oz Bottle		
Belt	☐ Medium ☐ Large		
Adhesive Remover Wipes (box of 50)	☐ One Size		
Tape:	☐ 1" ☐ 2" ☐ 3" ☐ Plastic (waterproof) ☐ Cloth (waterproof)		
Medipore:	☐ 2" ☐ 4"		
Other:			

REFERRAL INFORMATION

Ref #: _____

Practice Name: _____ Fax: _____
Office Address: _____ Email: _____
Phone: _____ Preferred Method of Contact? ☐ Phone ☐ Fax ☐ Email
Contact Person: _____

Physician Name: _____ NPI#: _____ Phone: (_____)_____-_____ Ext. _____