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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

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

PRODUCT SELECTION

Wound Dressing	Frequency of Change	Qty	Select Wound (with X)		
			W1	W2	W3
Collagen <input type="checkbox"/> 2x2 <input type="checkbox"/> 4x4 <input type="checkbox"/> Rope <input type="checkbox"/> Powder 1gm					
Collagen w/ Silver <input type="checkbox"/> 2x2					
Calcium Alginate <input type="checkbox"/> 2x2 <input type="checkbox"/> 4x4.75 <input type="checkbox"/> 4x8 <input type="checkbox"/> Rope					
Calcium Alginate w/ Silver <input type="checkbox"/> 2x2 <input type="checkbox"/> 4x4.75 <input type="checkbox"/> 4x8 <input type="checkbox"/> Rope					
Hydrocolloid <input type="checkbox"/> 2x2 <input type="checkbox"/> 4x4 <input type="checkbox"/> 6x6 <input type="checkbox"/> Thin					
Hydrogel/Hydrogel Sheets <input type="checkbox"/> 3oz. tube <input type="checkbox"/> 8oz. spray <input type="checkbox"/> 2x2 <input type="checkbox"/> 4x4					
Foam Dressing <input type="checkbox"/> 4x4 <input type="checkbox"/> 4x5 <input type="checkbox"/> 6x6					
Foam Dressing w/ Silver <input type="checkbox"/> 4x4 <input type="checkbox"/> 4x5					
ABD Pad <input type="checkbox"/> 5x9 <input type="checkbox"/> 8x7.5 <input type="checkbox"/> 8x10					
Antimicrobial Roll Gauze <input type="checkbox"/> 2" <input type="checkbox"/> 3" <input type="checkbox"/> 4"					
Sterile Conforming Roll Gauze <input type="checkbox"/> 2" <input type="checkbox"/> 3" <input type="checkbox"/> 4"					
Kerlix <input type="checkbox"/> Antimicrobial 4.5" <input type="checkbox"/> 4.5"					
Gauze Pad Antimicrobial <input type="checkbox"/> 2x2 <input type="checkbox"/> 4x4 <input type="checkbox"/> 6.75x6.75					
Gauze Pad Sterile (2 per change) <input type="checkbox"/> 2x2 <input type="checkbox"/> 4x4 <input type="checkbox"/> 4x8					
Composite Dressing <input type="checkbox"/> 4x4 <input type="checkbox"/> 6x6 <input type="checkbox"/> 6x8 (size includes border)					
Foam Dressing w/ Border <input type="checkbox"/> 3x3 <input type="checkbox"/> 4x4 <input type="checkbox"/> 5x5 (size includes border)					
Waterproof Tape <input type="checkbox"/> 1" <input type="checkbox"/> 2" <input type="checkbox"/> 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: 5 10 15 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.

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: ____/____/____