Burmans
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

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.		☐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
Collagen ☐2x2 ☐4x4 ☐Rope				
Collagen w/ Silver ☐2x2				
Calcium Alginate ☐2x2 ☐4x4.75 ☐4x8 ☐Rope				
Calcium Alginate w/ Silver ☐2x2 ☐4x4.75 ☐4x8 ☐Rope				
Foam Dressing ☐4x4 ☐4x5 ☐6x6				
Foam Dressing w/ Border ☐3x3 ☐4x4 ☐5x5 (size includes border)				
Foam Dressing w/ Silver ☐4x4 ☐4x5				
Other:				

Wound Dressing	Qty	Select Wound (with X) W1	W2	W3
ABD Pad ☐5x9 ☐8x7.5 ☐8x10				
Antimicrobial Roll Gauze ☐2" ☐3" ☐4"				
Sterile Conforming Roll ☐2" ☐3" ☐4"				
Kerlix ☐Antimicrobial 4.5" ☐4.5"				
Gauze Pad Antimicrobial ☐2x2 ☐4x4 ☐6.75x6.75				
Gauze Pad Sterile (2 per change) ☐2x2 ☐4x4 ☐4x8				
Composite Dressing ☐4x4 ☐6x6 ☐6x8 (size includes border)				
Waterproof Tape: ☐1" ☐2" ☐4"				

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.*

UROLOGICAL ASSESSMENT

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

UROLOGICAL PRODUCT SELECTION

INTERMITTENT CATHETERS/TRAYS

Type: ☐ Red Rubber ☐ Coude **(medical records required)** ☐ Straight ☐ Closed System **(medical records required)**
☐ Hydrophilic Coude ☐ Hydrophilic Straight

Size: ☐6FR ☐8FR ☐10FR ☐12FR ☐14FR ☐16FR ☐18FR ☐Other ***Length:*** ☐6" (female) ☐10" (pediatric) ☐16" (adult)

Lubricant: ☐ Ind. Packets ☐ Tube
Qty: _____
☐ Intermittent Catheter Tray

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

FOLEY CATHETER/TRAY

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

UROLOGY ACCESSORIES

☐ Saline (100ml)	Qty: _____	☐ Leg Strap:	Qty: _____	☐ Tape ☐1" ☐2" ☐4"	Qty: _____
☐ Appliance cleaner	Qty: _____	☐ AMD Split Gauze	Qty: _____	☐ Anchoring Device	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**

OSTOMY PRODUCT SELECTION

Check all products that apply			Qty	Product #
1 Piece Pouch	☐ Closed	☐ Drainable		
2 Piece Pouch	☐ Closed	☐ Drainable		
Wafer (for 2 Piece Pouch)	☐ Flat	☐ Convex		
Stoma Size:_____				

OSTOMY ACCESSORIES

Check all products that apply		Qty
Bedside Urinary Drainage Bag	☐ 2000 ml	
Barrier Ring	☐2" ☐4"	
Stoma Paste	☐ 2 oz.	
Skin Prep Wipes	☐ 1 Box	
Barrier Strips	☐ 1 Box	
Lubricating Deodorant	☐ 8 oz Bottle	
Belt	☐ Medium ☐ Large	
Adhesive Remover Wipes	☐ 1 Box	
Waterproof Tape	☐1" ☐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. _____