Continuum
a CHC Solutions Company

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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.		☐ 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

PRODUCT SELECTION

Wound Dressing		Frequency of Change	Qty	Select Wound (with X) W1	W2	W3
Collagen	☐ 2x2 ☐ 4x4 ☐ Rope ☐ Powder 1gm					
Collagen w/ Silver	☐ 2x2					
Calcium Alginate	☐ 2x2 ☐ 4x4.75 ☐ 4x8 ☐ Rope					
Calcium Alginate w/ Silver	☐ 2x2 ☐ 4x4.75 ☐ 4x8 ☐ Rope					
Hydrocolloid	☐ 2x2 ☐ 4x4 ☐ 6x6 ☐ Thin					
Hydrogel/Hydrogel Sheets	☐ 3oz. tube ☐ 8oz. spray ☐ 2x2 ☐ 4x4					
Foam Dressing	☐ 4x4 ☐ 4x5 ☐ 6x6					
Foam Dressing w/ Silver	☐ 4x4 ☐ 4x5					
ABD Pad	☐ 5x9 ☐ 8x7.5 ☐ 8x10					
Sterile Conforming Roll Gauze	☐ 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)					
Foam Dressing w/ Border	☐ 3x3 ☐ 4x4 ☐ 5x5 (size includes border)					
Waterproof Tape	☐ 1" ☐ 2" ☐ 4"					
Other:						
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: _____/_____/_____