

****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.		<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

WOUND CARE PRODUCT SELECTION

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

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
 Lubricant: Ind. Packets Tube
 Qty: _____
 Size: 6FR 8FR 10FR 12FR 14FR 16FR 18FR Other Length: 6" (female) 10" (pediatric) 16" (adult)
 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 <input type="checkbox"/> Closed <input type="checkbox"/> Drainable		
2 Piece Pouch <input type="checkbox"/> Closed <input type="checkbox"/> Drainable		
Wafer (for 2 Piece Pouch) <input type="checkbox"/> Flat <input type="checkbox"/> Convex		
Stoma Size: _____		

OSTOMY ACCESSORIES

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