

ATTENTION

The following information must be attached for all wound care orders.

- Patient demographics
- Wound assessment
- Insurance information

If you have questions, please contact your CHC Solutions account manager.

****Patient demographics, wound assessment & insurance info must be attached****

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: _____

PRODUCT SELECTION

Wound Dressing	Frequency of Change	Qty
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		
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"/> 4x5 <input type="checkbox"/> 4x10 <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"		
Manuka Honey Gel (Cash Pay Only) <input type="checkbox"/> 1.5oz.		
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 Vashe Wound Cleanser 8.5oz. (Cash Pay Only)
*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

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, 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: ____/____/____

Call 1.800.220.5262 or visit www.chcsolutions.com for additional information.

Patient Name: _____

Date of Birth: ___/___/_____

Evaluation Date: ___/___/_____

WOUND 1 ASSESSMENT

ICD-10 Code	Wound Type	Wound Location	Length x Width x Depth	Stage/Thickness	Drainage	Surgically Created/Date
		<input type="checkbox"/> Left <input type="checkbox"/> Right Body Part: _____		<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 <input type="checkbox"/> Very Hvy w/ Strikethrough	<input type="checkbox"/> YES ___/___/_____
Debridement/Date: <input type="checkbox"/> Yes ___/___/_____		Select Type: <input type="checkbox"/> Mechanical <input type="checkbox"/> Autolytic <input type="checkbox"/> Chemical <input type="checkbox"/> Surgical				
Primary Dressing:			Secondary & Cover/Securement Dressings:		Freq. of Change:	

WOUND 2 ASSESSMENT

ICD-10 Code	Wound Type	Wound Location	Length x Width x Depth	Stage/Thickness	Drainage	Surgically Created/Date
		<input type="checkbox"/> Left <input type="checkbox"/> Right Body Part: _____		<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 <input type="checkbox"/> Very Hvy w/ Strikethrough	<input type="checkbox"/> YES ___/___/_____
Debridement/Date: <input type="checkbox"/> Yes ___/___/_____		Select Type: <input type="checkbox"/> Mechanical <input type="checkbox"/> Autolytic <input type="checkbox"/> Chemical <input type="checkbox"/> Surgical				
Primary Dressing:			Secondary & Cover/Securement Dressings:		Freq. of Change:	

WOUND 3 ASSESSMENT

ICD-10 Code	Wound Type	Wound Location	Length x Width x Depth	Stage/Thickness	Drainage	Surgically Created/Date
		<input type="checkbox"/> Left <input type="checkbox"/> Right Body Part: _____		<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 <input type="checkbox"/> Very Hvy w/ Strikethrough	<input type="checkbox"/> YES ___/___/_____
Debridement/Date: <input type="checkbox"/> Yes ___/___/_____		Select Type: <input type="checkbox"/> Mechanical <input type="checkbox"/> Autolytic <input type="checkbox"/> Chemical <input type="checkbox"/> Surgical				
Primary Dressing:			Secondary & Cover/Securement Dressings:		Freq. of Change:	

WOUND 4 ASSESSMENT

ICD-10 Code	Wound Type	Wound Location	Length x Width x Depth	Stage/Thickness	Drainage	Surgically Created/Date
		<input type="checkbox"/> Left <input type="checkbox"/> Right Body Part: _____		<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 <input type="checkbox"/> Very Hvy w/ Strikethrough	<input type="checkbox"/> YES ___/___/_____
Debridement/Date: <input type="checkbox"/> Yes ___/___/_____		Select Type: <input type="checkbox"/> Mechanical <input type="checkbox"/> Autolytic <input type="checkbox"/> Chemical <input type="checkbox"/> Surgical				
Primary Dressing:			Secondary & Cover/Securement Dressings:		Freq. of Change:	

Clinician Signature (Name, Credentials): _____

Date: ___/___/_____