

**\*\*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 1.855.201.3724 or visit [www.chcsolutions.com](http://www.chcsolutions.com) for additional information.