# Wound Care Prescription Form

Phone: (888) 244-6421

Fax: (800) 975-6321

*In order to process your patient's order we need the following documentation faxed along with this completed form:*

1. ***PATIENT DEMOGRAPHICS** - (Insurance & Physical Address)*
2. ***ASSESSMENT RECORD** - (Fill in below or attach separately)*

| ✓ | ORDER TYPE *(Please Specify)* |
|---|---|
| | **NEW** - *This order replaces all other existing orders on file.* |
| | **ADD** - *Please add these products to existing order on file.* |

| REFERRING FACILITY | |
|---|---|
| NAME | |
| CITY/STATE | |
| PHONE | |
| FAX | |

| CASE MANAGER |
|---|
| |

| RX DATE: | |
|---|---|
| Patient's Name: | |

**In what increments would you like the patients order filled? *(Days)*** 15 30
***(Patient's order will be filled in 15 day increments if not otherwise indicated)***

**Is this patient currently being seen by Home Health Services?** Yes No
**Have the patient's wound(s) ever been debrided?** Yes No
**Has the patient been shown how to apply the requested dressings?** Yes No

| DRESSINGS | REQUIRED DRAINAGE | MAX UNITS PER MONTH | FREQUENCY OF CHANGE | WOUND NUMBER 1 | 2 | 3 | 4 |
|---|---|---|---|---|---|---|---|
| PRISMA MATRIX | ANY | 30 | | | | | |
| PROMOGRAN | ANY | 30 | | | | | |
| CALCIUM ALGINATE W/ SILVER | MOD-HEAVY | 30 | | | | | |
| CALCIUM ALGINATE | MOD-HEAVY | 30 | | | | | |
| XEROFORM | ANY | 30 | | | | | |
| ADAPTIC | ANY | 30 | | | | | |
| HYDROGEL | NONE-LOW | 3 OZ | | | | | |
| FOAM DRESSING | MOD-HEAVY | 12 | | | | | |
| FOAM DRESSING W/ BORDER | MOD-HEAVY | 12 | | | | | |
| ABD PAD | MOD-HEAVY | 30 | | | | | |
| ANTIMICROBIAL BULKY ROLL GAUZE | ANY | 30 | | | | | |
| CONFORMING ROLL GAUZE | ANY | 30 | | | | | |
| STERILE GAUZE 2X2 4X4 | ANY | 100 | | | | | |
| ANTIMICROBIAL GAUZE SPONGE | ANY | 30 | | | | | |
| TAPE SIZE:________ | ANY | 2 ROLLS | | | | | |
| OTHER: | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

| COMPRESSION STOCKINGS | | | |
|---|---|---|---|
| *PATIENT MUST HAVE AN OPEN VENIOUS ULCER TO QUALIFY* | | | |
| *PLEASE CHECK SELECTIONS* | | | |
| | 30-40 mmHg | | 40-50 mmHg |

| LEG | CIRCUMFERENCE *(INCHES)* ANKLE | CALF | LENGTH *HEEL TO BACK OF KNEE* |
|---|---|---|---|
| RIGHT | | | |
| LEFT | | | |

| ✓ | COMPRESSION STOCKINGS |
|---|---|
| | CAROLON MULTI-LAYER COMPRESSION SYSTEM |
| | CIRCAID-JUXTA LITE |
| | MEDIVEN ULCER KIT - 2 LAYER W/ SILVER |
| | JUZO DYNAMIC |
| | MEDIVEN PLUS W/ MEDISILK |

## WOUND ASSESSMENT

| WOUND | ICD9 CODES/DESCRIPTION *(e.g. 707.19 or diabetic ulcer)* | SIZE *(L x W x D)* | LOCATION *(e.g. Left Ankle)* | EXUDATE |
|---|---|---|---|---|
| 1 | | | | N L M H |
| 2 | | | | N L M H |
| 3 | | | | N L M H |
| 4 | | | | N L M H |

| ✓ | PROVIDERS APPROVAL |
|---|---|
| | |
| NPI # | |
| SIGNATURE | * |

*** I attest by my signature that it is my intention for this prescription to remain valid until, the underlying disease/diagnosis described above is resolved or otherwise directed by the signer.**

### PATIENT'S APPROVAL

I request that payment of my insurance benefits be made to Prism Medical Products, L.L.C. 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. I authorize any holder of my medical information to release to Prism Medical Products, L.L.C. any information needed to determine benefits payable for these supplies or services. Further, I authorize Prism Medical Products, L.L.C. to forward my medical records to the medical professionals in my care and/or make copies of said records.

| PATIENT'S SIGNATURE | **X** |
|---|---|