WOUND CARE ORDER FORM

Phone: (888) 244-6421
Fax: (800) 975-6321
WEB: WWW.PRISM-MEDICAL.COM

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)

GENERAL INFORMATION *(Section 1)*

REFERRING FACILITY	
NAME	
CITY/STATE	
PHONE	
FAX	
CASE MANAGER	

PATIENT INFORMATION	
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 30 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

PRODUCT INFORMATION *(Section 2)*

COMPRESSION GARMENTS

PLEASE SELECT COMPRESSION LEVEL

	30-40 mmHg		40-50 mmHg

PLEASE PROVIDE LEG MEASUREMENTS
(Circumference of ankle and calf. Length from the back of the knee to the heel)

(IN INCHES)	ANKLE	CALF	LENGTH
RIGHT			
LEFT			

PLEASE SELECT GARMENT TYPE(S)

✓	**GRADIENT COMPRESSION STOCKINGS**
	SINGLE LAYER STOCKING
	DUAL LAYER STOCKING
	MEDI DUAL LAYER
	OTHER:_____
✓	**GRADIENT COMPRESSION WRAP**
	JUXTA LITE
	OTHER:_____

DRESSINGS	REQUIRED DRAINAGE	MAX UNITS PER MONTH	FREQUENCY OF CHANGE	WOUND NUMBER 1	2	3	4
COLLAGEN W/ SILVER	ANY	30					
COLLAGEN	ANY	30					
CALCIUM ALGINATE W/ SILVER	MOD-HEAVY	30					
CALCIUM ALGINATE	MOD-HEAVY	30					
HYDROCOLLOID	LIGHT-MOD	12					
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:							

PLEASE CIRCLE ANY MEDICALLY NECESSARY ITEMS THAT SHOULD BE INCLUDED
GLOVES - SKIN PREP - SALINE - STERILE WATER - COTTON TIP APPLICATORS - ADHESIVE REMOVER

WOUND ASSESSMENT *(Section 3)*

WOUND	DESCRIPTION *(e.g. 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

AUTHORIZATIONS *(Section 4)*

COORDINATION OF CARE

By my signature below I attest that I am a clinician providing medically necessary health care to the associated patient who requires coordination of care and you have authority to coordinate care on behalf of my patient. Furthermore, the patient has chosen Prism Medical Products to assist in providing the requested care by either; providing product, verifying insurance benefits, billing for service or coordinating care for the associated patient should direct service not be an option.

NAME		POSITION		SIGN/DATE	DATE:_____

PROVIDER'S APPROVAL

(PRINT NAME)

NPI #	
SIGN/DATE	* DATE:_____

* I attest by my signature that 1) the requested supplies are medically necessary and 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, 2) the patient has been instructed on the specific use of the requested supplies and is competent to perform dressing changes, and 3) the supplier should size the requested supplies pursuant to the associated Local Coverage Determination for Surgical Dressings.

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. Furthermore, my physician has instructed me on the specific use of the requested supplies and I am competent to utilize the supplies as instructed

PATIENT'S SIGNATURE	X

SUBMIT