

(SECTION 1) GENERAL INTAKE INFORMATION

PATIENT'S NAME: ORDER START DATE: PATIENT PHONE: PATIENT DOB: REFERRAL FACILITY: CITY: STATE: REFERRAL PHONE: FAX:

GENERAL INFORMATION

PHONE: (888) 244-6421 FAX: (800) 975-6321 WWW.PRISM-MEDICAL.COM



Please fill out the entire form COMPLETELY and include patient's demographic in order to avoid delays in service.

(SECTION 2) WOUND ASSESSMENT

Table with 4 columns: WOUND 1, WOUND 2, WOUND 3. Rows include DESCRIPTION/ICD-10, WOUND EXUDATE, WOUND LOCATION, WOUND SIZE, and QUALIFYING WOUND.

(SECTION 3) WOUND CARE PRODUCTS

DISPENSING FREQUENCY EVERY: 15 (DAYS) 30 (DAYS) DURATION OF NEED: 90 (DAYS) OTHER: (DAYS)

ADVANCED DRESSINGS, FILLERS, PADS, AND COVERS

Table with 4 columns: WOUND 1 FREQUENCY OF CHANGE, WOUND 2 FREQUENCY OF CHANGE, WOUND 3 FREQUENCY OF CHANGE. Lists various dressing types like Calcium Alginate, Collagen, Foam, Hydrogel, etc.

GRADIENT COMPRESSION

Table for Gradient Compression including Compression Level (30-40 mmHg, 40-50 mmHg), Leg Measurements (Calf, Ankle, Length), Frequency of Change, and Products (Compression Stockings, Wraps).

ADDITIONAL ITEMS: GLOVES, SALINE, SKIN PREP, STERILE WATER, COTTON TIP APPLICATORS, ADHESIVE REMOVER

NOTES

DRESSING SIZE: PURSUANT TO THE LCD "DRESSING SIZE MUST BE BASED ON AND APPROPRIATE TO THE SIZE OF THE WOUND." PROVIDER'S SIGNATURE BELOW INDICATES SUPPLIER SHOULD USE THE PROVIDED WOUND SIZE(S) TO DETERMINE APPROPRIATE DRESSING SIZE.

REFILLS: PROVIDER'S SIGNATURE INDICATES THAT NUMBER OF REFILLS SHOULD BE EQUAL TO; DURATION OF NEED DIVIDED BY DISPENSING FREQUENCY.

QUANTITY: PROVIDER'S SIGNATURE INDICATES THAT QUANTITY OF DRESSINGS DISPENSED PER ORDER/REFILL SHOULD BE EQUAL TO; FREQUENCY OF CHANGE TIMES DISPENSING FREQUENCY. ADDITIONALLY THE PATIENT IS COMPETENT, HAS BEEN INSTRUCTED ON PROPER USE AND SHOULD NOT USE MORE THAN ONE DRESSING PER DAY, PER EACH PRIMARY AND/OR SECONDARY DRESSING(S) ORDERED.

(SECTION 4) AUTHORIZATIONS AND SIGNATURES

PROVIDER'S NAME: NPI: SIGNATURE: (DATE) VERBAL ORDER: YES NO (IF YES, PLEASE LIST THE ASSISTING CASE MANAGER BELOW) CASE MANAGER ASSISTING WITH VERBAL ORDER: (PRINT NAME) SUPPLIER SIGNATURE: (DATE)

(SECTION 5) COORDINATION OF CARE

I ATTEST THAT I AM A PROVIDER/CLINICIAN PROVIDING NECESSARY HEALTH CARE TO THE ASSOCIATED PATIENT WHO REQUIRES COORDINATION OF CARE AND PRISM HAS THE AUTHORITY TO COORDINATE CARE ON BEHALF OF MY PATIENT. PROVIDER/CLINICIAN COORDINATING CARE: (PRINT NAME) CLINICIAN SIGNATURE: (DATE)