PLEASE FILL OUT THE ENTIRE FORM AND INCLUDE THE PATIENT'S DEMOGRAPHIC TO **AVOID DELAYS**.

PRISM
HOME MEDICAL SUPPLY SPECIALISTS

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

(SECTION 1) GENERAL INTAKE INFORMATION

PATIENT NAME:_____ ***ORDER START DATE:*** ___/___/____
PATIENT PHONE: (_____)_____ PATIENT DOB: _____/_____/_____
REFERRAL FACILITY: _____ CITY:_____ STATE:____
REFERRAL PHONE: (_____)_____ FAX: (_____)_____

(SECTION 2) WOUND ASSESSMENT

	WOUND 1	WOUND 2	WOUND 3
DESCRIPTION/ICD-10			
WOUND EXUDATE	☐ NONE ☐ LOW ☐ MOD ☐ HVY	☐ NONE ☐ LOW ☐ MOD ☐ HVY	☐ NONE ☐ LOW ☐ MOD ☐ HVY
WOUND LOCATION	_____ ☐ LT ☐ RT	_____ ☐ LT ☐ RT	_____ ☐ LT ☐ RT
WOUND SIZE (LxWxD)	x x (cm)	x x (cm)	x x (cm)
HAS THE WOUND BEEN DEBRIDED?	☐ YES, DATE ___/___/___ ☐ NO	☐ YES, DATE ___/___/___ ☐ NO	☐ YES, DATE ___/___/___ ☐ NO
WOUND THICKNESS	☐ FULL ☐ PARTIAL	☐ FULL ☐ PARTIAL	☐ FULL ☐ PARTIAL

DURATION OF NEED	☐ **90 DAYS** ☐ _____ **DAYS** *(FREQUENCY OF CHANGE AND DURATION OF NEED WILL BE USED TO ASSESS QUANTITY TO BE DISPENSED)*

(SECTION 3) WOUND CARE PRODUCTS

PRODUCTS *Items designated by an *asterisk require FULL thickness for insurance coverage.*	WOUND 1 *FREQUENCY OF CHANGE*	WOUND 2 *FREQUENCY OF CHANGE*	WOUND 3 *FREQUENCY OF CHANGE*
*CALCIUM ALGINATE DRESSING			
*SUPER ABSORBER (FIBER GEL DRESSING)			
*COLLAGEN DRESSING			
*FOAM DRESSING			
*BORDERED FOAM			
*SILICONE BORDERED FOAM			
*HYDROGEL FILLER			
*HYDROGEL DRESSING			
*ABD PAD			
HYDROCOLLOID DRESSING			
CONTACT LAYER			
ROLL GAUZE			
GAUZE			
ANTIMICROBIAL GAUZE SPONGE			
IMPREGNATED GAUZE			
TAPE			
OTHER:			

GRADIENT COMPRESSION

PRODUCTS

SINGLE LAYER STOCKING	☐LT ☐RT
DUAL LAYER STOCKING	☐LT ☐RT
COMPRESSION WRAP	☐LT ☐RT
OTHER:	☐LT ☐RT

MEASUREMENTS (cm)

(CALF)	_____LT_____RT
(ANKLE)	_____LT_____RT
(LENGTH)	_____LT_____RT

COMPRESSION LEVEL

30-40 mmHg	☐LT ☐RT
40-50 mmHg	☐LT ☐RT

FREQUENCY OF CHANGE

MONTHLY	☐LT ☐RT
OTHER:_____	☐LT ☐RT

INSURANCE COVERAGE

DOES THE PATIENT HAVE A DEBRIDED OR SURGICALLY CREATED OPEN VENOUS STASIS ULCER? ☐YES ☐NO

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

(SECTION 4) SUPPLY ASSESSMENT

DOES THE PATIENT CURRENTLY HAVE ANY OF THE REQUESTED PRODUCT(S) AT HOME? ☐ **YES** ☐ **NO**

*IF **YES**, LIST THE QUANTITY REMAINING OF **EACH** PRODUCT THE PATIENT CURRENTLY HAS IN THE NOTES SECTION.*

(SECTION 5) NOTES

(SECTION 6) AUTHORIZATIONS

IS THE PATIENT REQUESTING COORDINATION OF CARE? ☐**YES** ☐**NO**
(THE PATIENT HAS CHOSEN PRISM TO ASSIST IN PROVIDING THE REQUESTED CARE BY EITHER; PROVIDING PRODUCT, VERIFYING INSURANCE BENEFITS, BILLING FOR SERVICE(S) OR COORDINATING CARE SHOULD DIRECT SERVICE NOT BE AN OPTION.)

(SECTION 7) PROVIDER SIGNATURE

PROVIDER'S NAME:_____
PROVIDER'S NPI:_____
SIGNATURE:_____
DATE:_____/_____/_____

****(If the PROVIDER listed herein is best reached at a location other than the referring facility detailed in Section 1, please provide the PROVIDER'S contact information below.)***

PROVIDER PHONE: (_____)_____
PROVIDER FAX: (_____)_____

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Patient Demographics Form

Form must be filled out entirely to complete the patient file.

Patient Name: (First) (Middle Initial) (Last Name)

Please enter name as it appears on the insurance card.

Date of Birth: **Social Security Number**:

Address:

City: **State**: **Zip**:

Best Contact Number:

Shipping Address:

Same as Billing

Alternate Ship To Address:

City: **State:** **Zip:**

Primary Insurance:

Carrier Name:

Policy Number: **Group Number:**

Phone Number:

Secondary Insurance:

Carrier Name:

Policy Number: **Group Number:**

Phone Number:

Notes:

SUBMIT

Info Taken By: