

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



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### (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                                                                        | WOUND 1                                                                                                          | WOUND 2             | WOUND 3             | GRADIENT COMPRESSION                                                                    |
|---------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------|---------------------|---------------------|-----------------------------------------------------------------------------------------|
| Items designated by an *asterisk require FULL thickness for insurance coverage. | FREQUENCY OF CHANGE                                                                                              | FREQUENCY OF CHANGE | FREQUENCY OF CHANGE | PRODUCTS                                                                                |
|                                                                                 |                                                                                                                  |                     |                     | LT RT                                                                                   |
|                                                                                 |                                                                                                                  |                     |                     | LT RT                                                                                   |
|                                                                                 |                                                                                                                  |                     |                     | LT RT                                                                                   |
|                                                                                 |                                                                                                                  |                     |                     | 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                                                                | CLEANSING KIT (SALINE, GLOVES, COTTON TIP APPLICATORS, SKIN PREP WIPES) USE SECTION 5 FOR ADDITIONAL INFORMATION |                     |                     |                                                                                         |

### (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: \_\_\_\_\_ \*(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'S NPI: \_\_\_\_\_ PROVIDER PHONE: (\_\_\_\_) \_\_\_\_\_  
SIGNATURE: \_\_\_\_\_ PROVIDER FAX: (\_\_\_\_) \_\_\_\_\_  
DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_