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

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

GRADIENT COMPRESSION

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

(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: (________)______________________________

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:

Info Taken By: