Advanced Care Solutions

COMPLETE MEDICAL SUPPLIES

WOUND CARE PRESCRIPTION FORM

Patient Name ____________________________________ ________________**DOB** ____/___/_____ __

Address:____**PHONE #** ________________

City ______________________ **State**____________ **ZIP CODE**________________________

Insurance Name:______________________________ ________**Id #** _____________________________

IF PATIENT UNDER HHA AGENCY NAME: ______________________________**PHONE #** ____________

REFILLS: ( ) 3 VISITS **START DATE:** ___/___/_____ **EQUIPMENT / SERVICES (1 order per month)**

Use "✓" to indicate primary and secondary dressings for each wound. Please specify quantities and dressing sizes for each wound. Supportive wound documentation must be included with all requests

PRIMARY DRESSING	WD1	QTY	WD2	QTY	WD3	QTY
	✓	Ea,BX	✓	Ea,BX	✓	Ea,BX
Collagen ____2x2 ____4x4						
Collagen AG ___2x2 ____4x4						
Calcium Alginate ___2x2 ___4x4 ___Rope						
Silver Alginate ___ 2x2 ____4x5 ___Rope						
Hydrogel __tube _____ 4x4 pad						
Silver Hydrogel ___ 1.5 oz tube __ 3 oz tube						
Hydrocolloids Thick/Thin ___ 2x2 __ 4x4						
Gauze ___ 2x2 ___ 4x4						
Gauze N/S ___2x2 ___4x4						
__ Xeroform __ Vaseline Gauze __ Adaptic						
Normal saline 100ml						

Other: (product, ref# if available and qty:

SECONDARY DRESSING	WD1	QTY	WD2	QTY	WD3	QTY
	✓	Ea,BX	✓	Ea,BX	✓	Ea,BX
ABD ___ 5x9 ____ 8x10						
Non Adherent Pad/Telfa 3x4						
Foam ___ 2x2 ____ 4x4						
Bordered Foam ___ 3x3 ___ 4x4						
Bordered Gauze ___ 4x4 ___ 6x6						
Kerlix/Bandage Roll						
Kling/conform ___ 2" ___ 3"___ 4" Roll						
Coban ___ 2" ____ 3" ____ 4" Roll						
Elastic Bandage ___ 2" ___ 3" ___ 4" Roll						
Cloth Tape ___ 1" ___ 2" ___ 3"						
Mefix Tape ___ 2" ___ 4"						
Paper Tape ___ 1" ___ 2" ___ 3"						
Unnaboot ___ 3" ___ 4" Roll						

WOUND 1	WOUND 2	WOUND 3
LOCATION: ______________	LOCATION______________	LOCATION ______________
LENGTH: ________________CM	LENGTH______________CM	LENGTH ______________CM
WIDTH:_________________ CM	WIDTH: ______________CM	WIDTH : ______________CM
DEPTH: _________________CM	DEPTH: ______________CM	DEPTH: _______________CM
DRAINAGE ______________	DRAINAGE ______________	DRAINAGE ______________

FREQUENCY CHANGE OF DRESSING: ( ) DAILY ( ) EVERY OTHER DAY ( ) ONCE A WEEK ( ) OTHER: ____________

IF ADDITIONAL WOUNDS PLEASE ATTACH INFORMATION ON A SEPARATE PAPER

PHYSICIAN ATTESTATION: I certify with my signature that I am the physician named below. The information contained on this Written Order is true and complete to the best of my knowledge. This patient was evaluated by me and treated for the condition as stated above. The patient's medical record accurately contains documentation to support medical need and utilization of the supplies prescribed by me. **This order for supplies is reasonable and necessary for the diagnosis and treatment of the patient's illness**. The patient and or caregiver has been trained on the proper use of the supplies and is capable of following these instructions. A copy of this signed order will be maintained on file as part of the patient's medical record and made available to Medicare or other Insurance for post payment review or audits.

PHISICIAN NAME: ____________________________ **NPI** __________________ **PHONE** _______________________

PHISICIAN SIGNATURE: ____

Instructions for Referral Submission

Fax or email completed form along with the documents listed below

- **Patient Face Sheet (containing current demographics and insurance)**
- **Medical Record (must include Diagnosis codes) with in last 30 days that confirms need for supplies based on condition**

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