

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	SECONDARY DRESSING	WD1	QTY	WD2	QTY	WD3	QTY
	✓	Ea,BX	✓	Ea,BX	✓	Ea,BX		✓	Ea,BX	✓	Ea,BX	✓	Ea,BX
Collagen 2x2 4x4							ABD 5x9 8x10						
Collagen AG 2x2 4x4							Non Adherent Pad/Telfa 3x4						
Calcium Alginate 2x2 4x4 Rope							Foam 2x2 4x4						
Silver Alginate 2x2 4x5 Rope							Bordered Foam 3x3 4x4						
Hydrogel tube 4x4 pad							Bordered Gauze 4x4 6x6						
Silver Hydrogel 1.5 oz tube 3 oz tube							Kerlix/Bandage Roll						
Hydrocolloids Thick/Thin 2x2 4x4							Kling/conform 2" 3" 4" Roll						
Gauze 2x2 4x4							Coban 2" 3" 4" Roll						
Gauze N/S 2x2 4x4							Elastic Bandage 2" 3" 4" Roll						
Xeroform Vaseline Gauze Adaptic							Cloth Tape 1" 2" 3"						
Normal saline 100ml							Mefix Tape 2" 4"						
Other: (product, ref# if available and qty:							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.

PHYSICIAN NAME: _____ NPI _____ PHONE _____

PHYSICIAN 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

PHONE# 877-748-1977

FAX# 877-748-1985

EMAIL: Intake@acsmedical.com