MAIL ORDER MEDICAL SUPPLIES

WOUND CARE ORDER FORM
Please fax to 228-400-1348 or 877-243-5077

Account Manager: Jack Marquez cell:786-208-0110 office: 228.334.5291 email: Jack@moms23.com

Patient Name ______________________ ❑ M ❑ F DOB ______________

❑ ***Patient has been notified of order***

PLEASE PROVIDE A FACESHEET WITH PATIENT DEMOGRAPHICS AND LATEST OFFICE NOTE WITH THE INITIAL ORDER

REFERRAL INFORMATION Referral Number ______________

Referral ______________________

Contact ______________________ Tel ______________

How would you prefer to be contacted:

❑ Phone ______________ ❑ Email ______________ ❑ Fax ______________

DIAGNOSIS ______________________

WOUND INFORMATION

	WOUND #1	WOUND #2	WOUND #3
Wound Type			
Location	❑ LT ❑ RT ________	❑ LT ❑ RT ________	❑ LT ❑ RT ________
Length X Width X Depth	X X	X X	X X
Stage/Thickness	❑ II ❑ III ❑ IV ❑ Partial ❑ Full	❑ II ❑ III ❑ IV ❑ Partial ❑ Full	❑ II ❑ III ❑ IV ❑ Partial ❑ Full
Drainage Amount	❑ Dry ❑ Min ❑ Mod ❑ Hvy	❑ Dry ❑ Min ❑ Mod ❑ Hvy	❑ Dry ❑ Min ❑ Mod ❑ Hvy
Frequency of Change			
Is Wound Debrided/Surgically Created?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Additional Wound Information			

PRODUCTS

Use "X" to indicate primary and secondary dressings for each wound. One dressing per change unless noted otherwise.

PRIMARY DRESSING	WND#1	WND#2	WND#3
Collagen 2x2 4x4			
Collagen with Silver 2x2 4x4			
Collagen Powder 1gram			
Calcium Alginate 2x2 4x4 4x8 Rope			
Silver Alginate 2x2 4x5 Rope			
Silver Hydrogel 1.5 oz tube 3 oz tube			
Hydrocolloids Thick/Thin 2x2 4x4 6x6			
Gauze 2x2 4x4 4x8			
Antimicrobial (AMD) Gauze 2x2 4x4			
Hydrogel 3 oz tube 2x2 pad 4x4 pad			
Other			
Other			
Cleansing Pack (Gauze, Saline, Gloves) – ***NEW PATIENTS ONLY*** ❑			

SECONDARY DRESSING	WND#1	WND#2	WND#3
ABD 5x9 8x7.5 8x10			
Foam 2x2 4x4 4x8			
Bordered Foam 4x4 (2x2 pad) 6x6 (4x4 pad) 6x8 (4x6 pad)			
Composite 4x4 (2x2 pad) 6x6 (4x4 pad) 6x8 (4x6 pad)			
Bordered Gauze 4x4 (2x2 pad) 6x6 (4x4 pad) 6x8 (4x6 pad)			
Kerlix 3" 4"			
Antimicrobial (AMD) Kerlix 4"			
Roll Gauze Conform 2" 3" 4"			
Antimicrobial (AMD) Roll Gauze Conform 2" 3" 4"			
Cloth Tape 1" 2"			
Medipore Tape 2" 4"			
Other			
Other			

Practice Name: ______________________ Fax: ______________

Address: ______________________ Phone: ______________

Physician's Name: **Q** ______________________ NPI#: ______________

Ordering Physician or Licensed Prescriber *(Please Print)* ______________________

Address: ______________________ Tel ______________ Fax ______________

Signature* ______________________ Date ______________ NPI# ______________

PRESCRIPTION VALID FOR: ❑ 30 days ❑ 60 days ❑ 90 days ***START DATE*** ______/______/______ ***DISPENSE:*** ❑ 30 day supply ❑ 2 week supply

I certify that this order is reasonable and medically necessary and not merely a convenience item or it is a mandated benefit. This document may serve as a confirmation of a verbal order and is also written in the patient's record. The forgoing information is true, accurate and complete, I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. **PLEASE KEEP A COPY OF THIS ORDER FOR YOUR PATIENT'S CHART.**