Home Care Delivered, Inc.

Referred By: *Name:* _____

Phone: _____

Physician's Order
Wound Care Supplies

Questions? 800-565-6167 ext. 6637

Fax: 888-565-4411

FAX completed form with ● **Physician's Signature** ● **Patient Face Sheet** ● **signed AOB**

Home Care Delivered, Inc. • Wound Management

1 Patient Information

Patient Name: _____ Phone: _____ Date of Birth: _____

Alternate Contact: _____ Alternate Phone: _____

Start Date: ____ / ____ / ____ (MM / DD / YY)

Duration of Need for Wound Supplies: ❍ 90 days ❍ other

Is this patient currently being seen by Home Health? ❍ no ❍ yes

Does this patient have additional medical supply needs: ❍ urology ❍ incontinence ❍ ostomy ❍ diabetes ❍ erectile dysfunction

2 Wound Information

	Wound 1	Wound 2	Wound 3
ICD-9 Code:			
Location:			
Type of wound: (i.e. pressure, venous stasis, surgical)			
Color of wound			
Has the wound been debrided? *(circle one)*	yes no	yes no	yes no
Stage *(if pressure ulcer)* or Thickness *(other wound types)* *(circle one)*	II III IV Partial Full Thickness	II III IV Partial Full Thickness	II III IV Partial Full Thickness
Size in cm: (L x W x D)	____cm x ____cm x ____cm	____cm x ____cm x ____cm	____cm x ____cm x ____cm
Frequency of dressing change			
Exudate *(circle one)*:	Light Moderate Heavy	Light Moderate Heavy	Light Moderate Heavy

3 Supplies Ordered

*** Indicate total quantity needed per month for each wound. ***

Dressing *(Please circle requested size)*		Wound 1 Primary	Wound 1 Secondary	Wound 2 Primary	Wound 2 Secondary	Wound 3 Primary	Wound 3 Secondary
Gauze, Sterile (2 units/package)	2 x 2 4 x 4	pks/month	pks/month	pks/month	pks/month	pks/month	pks/month
ABD Pads	5 x 9 8 x 10	pks/month	pks/month	pks/month	pks/month	pks/month	pks/month
Conform Bandage Roll	3" width	rolls/month	rolls/month	rolls/month	rolls/month	rolls/month	rolls/month
Kerlix™ Rolled Gauze	4.5" width	rolls/month	rolls/month	rolls/month	rolls/month	rolls/month	rolls/month
Micropore Paper Tape	1" 2"		rolls/month		rolls/month		rolls/month
Waterproof Fixation Cloth Tape	2"		rolls/month		rolls/month		rolls/month
Alginate	2 x 2 4 x 4	/month		/month		/month	
Silver Alginate	2x2 4x4.7	/month		/month		/month	
Alginate Rope / Silver Alginate Rope	.75 x 12"	/month		/month		/month	
Non-Adherent Oil Emulsion Dressing	3 x 3	/month		/month		/month	
Foam	3 x 3 4 x 4	/month	/month	/month	/month	/month	/month
Adhesive Foam	3 x 3 4 x 4	/month	/month	/month	/month	/month	/month
Hydrocolloid	4 x 4	/month	/month	/month	/month	/month	/month
Hydrogel	3 oz. tube	tube/month		tube/month		tube/month	

4 Physician Information

Physician's Name: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

NPI #: _____ License #: _____

Physician's Signature _____ **Date** ____ / ____ / ____ (MM / DD / YY)

By my signature above, I confirm that the patient has the medical condition(s) listed and is being treated by me. All the information set forth in this Physician's Order accurately reflects the patient's medical condition(s) and the treatment regimen that I have prescribed. The patient's wounds are evaluated on a monthly basis unless otherwise documented in the medical record. The patient/caregiver is able to use the prescribed supplies. My office has informed the patient that this order has been submitted to a DME supplier on behalf of the patient.

5 Assignment of Benefits (AOB)

I request that payment of my insurance benefits (Medicare, Medicaid or other payor) be made to Home Care Delivered, Inc. for any supplies or services furnished to me by Home Care Delivered, Inc. I understand that I am responsible to pay all amounts that are not covered by my insurance. I authorize any holder of my medical information to release to Home Care Delivered, Inc. any information needed to determine benefits payable for these supplies or services. In addition, I authorize Home Care Delivered, Inc. to release my medical records to insurers, as well as medical professionals, involved in my care. I authorize Home Care Delivered, Inc. to contact me by telephone, email or mail regarding my medical supplies. Furthermore, I authorize shipment of my initial order in the event Home Care Delivered, Inc. is unable to reach me by phone.

Patient's Signature: _____ **Date:** ____ / ____ / ____ (MM / DD / YY)

If patient is unable to sign due to a physical or mental condition, an Authorized Representative of the patient must sign the patient's name and date above and complete the section below. By signing on behalf of the patient, you acknowledge that you have authority to do so.

Authorized Representative's Signature: _____ Relationship to Patient: _____

Authorized Representative's Name: _____ Physical/Mental Reason Patient Is Unable To Sign: _____

Address: _____ City: _____ State: _____ Zip: _____

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