PRISM MEDICAL PRODUCTS

Wound Care Prescription Form

Phone: (888) 244-6421

Fax: (800) 975-6321

In order to process your patient's order we need the following documentation faxed along with this completed form:

1. ***PATIENT DEMOGRAPHICS*** *- (Insurance & Physical Address)*
2. ***ASSESSMENT RECORD*** *- (Fill in below or attach separately)*

✓	**ORDER TYPE** ***(Please Specify)***
	NEW - *This order replaces all other existing orders on file.*
	ADD - *Please add these products to existing order on file.*

REFERRING FACILITY	
NAME	
CITY/STATE	
PHONE	
FAX	

CASE MANAGER

RX DATE:	
Patient's Name:	

In what increments would you like the patients order filled? ***(Days)*** 15 30

(Patient's order will be filled in 15 day increments if not otherwise indicated)

Is this patient currently being seen by Home Health Services? Yes No

Have the patient's wound(s) ever been debrided? Yes No

Has the patient been shown how to apply the requested dressings? Yes No

COMPRESSION STOCKINGS			
PATIENT MUST HAVE AN OPEN VENOUS ULCER TO QUALIFY			
PLEASE CHECK SELECTIONS			
	30-40 mmHg		40-50 mmHg

LEG	**CIRCUMFERENCE** *(INCHES)*		**LENGTH**
	ANKLE	CALF	*HEEL TO BACK OF KNEE*
RIGHT			
LEFT			

✓	**COMPRESSION STOCKINGS**
	CAROLON MULTI-LAYER COMPRESSION SYSTEM
	CIRCAID-JUXTA LITE
	MEDIVEN ULCER KIT - 2 LAYER W/ SILVER
	JUZO DYNAMIC
	MEDIVEN PLUS W/ MEDISILK

DRESSINGS	**REQUIRED DRAINAGE**	**MAX UNITS PER MONTH**	**FREQUENCY OF CHANGE**	**WOUND NUMBER**			
				1	**2**	**3**	**4**
ENLUXTRA 2X2	MOD-HEAVY	30					
ENLUXTRA 4X4	MOD-HEAVY	30					
ENLUXTRA 6X6	MOD-HEAVY	30					
ABD PAD	MOD-HEAVY	30					
ANTIMICROBIAL BULKY ROLL GAUZE	ANY	30					
CONFORMING ROLL GAUZE	ANY	30					
STERILE GAUZE 2X2 4X4	ANY	100					
ANTIMICROBIAL GAUZE SPONGE	ANY	30					
CAST PADDING	ANY	30					
COBAN	ANY	8 ROLLS					
COMPRILAN	ANY	8 ROLLS					
TAPE SIZE:_____	ANY	2 ROLLS					
OTHER:							

WOUND ASSESSMENT

WOUND	**ICD9 CODES/DESCRIPTION** *(e.g. 707.19 or diabetic ulcer)*	**SIZE** *(L x W x D)*	**LOCATION** *(e.g. Left Ankle)*	**EXUDATE**
1				**N L M H**
2				**N L M H**
3				**N L M H**
4				**N L M H**

✓	**PROVIDERS APPROVAL**
NPI #	
SIGNATURE	*

*** I attest by my signature that it is my intention for this prescription to remain valid until, the underlying disease/diagnosis described above is resolved or otherwise directed by the signer.**

PATIENT'S APPROVAL

I request that payment of my insurance benefits be made to Prism Medical Products, L.L.C. for any supplies or services they provide me. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home cannot be returned if opened. I authorize any holder of my medical information to release to Prism Medical Products, L.L.C. any information needed to determine benefits payable for these supplies or services. Further, I authorize Prism Medical Products, L.L.C. to forward my medical records to the medical professionals in my care and/or make copies of said records.

PATIENT'S SIGNATURE	**X**