(SECTION 1) GENERAL INTAKE INFORMATION

PATIENT'S NAME: _____ ***ORDER START DATE:*** ____/____/____

PATIENT PHONE: (____) _____ PATIENT DOB: ____/____/____

REFERRAL FACILITY: _____ CITY: _____ STATE: _____

REFERRAL PHONE: (____) _____ FAX: (____) _____

GENERAL INFORMATION

PHONE: (888) 244-6421

FAX: (800) 975-6321

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PRISM
HOME MEDICAL SUPPLY SPECIALISTS

Please fill out the entire form ***COMPLETELY*** and include patient's demographic in order to avoid delays in service.

(SECTION 2) WOUND ASSESSMENT

	WOUND 1	WOUND 2	WOUND 3
DESCRIPTION/ICD-10			
WOUND EXUDATE	☐ moderate ☐ heavy	☐ moderate ☐ heavy	☐ moderate ☐ heavy
WOUND LOCATION	_____ ☐ LT ☐ RT	_____ ☐ LT ☐ RT	_____ ☐ LT ☐ RT
WOUND SIZE * (L x W x D)	____ x ____ x ____ (cm)	____ x ____ x ____ (cm)	____ x ____ x ____ (cm)
QUALIFYING WOUND	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

(SECTION 3) WOUND CARE PRODUCTS

DISPENSING FREQUENCY EVERY: ☐ 15 (DAYS) ☐ 30 (DAYS) **DURATION OF NEED:** ☐ 90 (DAYS) ☐ OTHER:_____ (DAYS)

ADVANCED DRESSINGS, FILLERS, PADS, AND COVERS

EVERY PRODUCT SELECTED MUST BE ASSOCIATED WITH A SPECIFIC WOUND(S).	WOUND 1 FREQUENCY OF CHANGE	WOUND 2 FREQUENCY OF CHANGE	WOUND 3 FREQUENCY OF CHANGE
ENLUXTRA 4"x4"			
ENLUXTRA 6"x6"			
HYDROGEL FILLER			
CONTACT LAYER			
ABD PAD			
ANTIMICROBIAL ROLL GAUZE			
CONFORMING ROLL GAUZE			
ANTIMICROBIAL GAUZE SPONGE			
STERILE GAUZE 2 x 2 4 x 4			
TAPE: SIZE:			
OTHER:			

GRADIENT COMPRESSION

COMPRESSION LEVEL

30–40 mmHg	☐ LT ☐ RT
40–50 mmHg	☐ LT ☐ RT
OTHER:_____	☐ LT ☐ RT

LEG MEASUREMENTS

☐ (cm) ☐ (in)

(CALF) LT:_____ RT:_____

(ANKLE) LT:_____ RT:_____

(LENGTH) LT:_____ RT:_____

FREQUENCY OF CHANGE

(LT) ☐ MONTHLY ☐ OTHER:_____

(RT) ☐ MONTHLY ☐ OTHER:_____

PRODUCTS

COMPRESSION STOCKINGS

SINGLE LAYER	☐ LT ☐ RT
DUAL LAYER	☐ LT ☐ RT
OTHER: _____	☐ LT ☐ RT

COMPRESSION WRAPS

COMPRESSION WRAP	☐ LT ☐ RT
OTHER: _____	☐ LT ☐ RT

ADDITIONAL ITEMS ☐ GLOVES ☐ SALINE ☐ SKIN PREP ☐ STERILE WATER ☐ COTTON TIP APPLICATORS ☐ ADHESIVE REMOVER

NOTES

DRESSING SIZE: PURSUANT TO THE LCD "DRESSING SIZE MUST BE BASED ON AND APPROPRIATE TO THE SIZE OF THE WOUND." PROVIDER'S SIGNATURE BELOW INDICATES SUPPLIER SHOULD USE THE PROVIDED WOUND SIZE(S) TO DETERMINE APPROPRIATE DRESSING SIZE.

REFILLS: PROVIDER'S SIGNATURE INDICATES THAT NUMBER OF REFILLS SHOULD BE EQUAL TO; DURATION OF NEED **DIVIDED** BY DISPENSING FREQUENCY.

QUANTITY: PROVIDER'S SIGNATURE INDICATES THAT QUANTITY OF DRESSINGS DISPENSED PER ORDER/REFILL SHOULD BE EQUAL TO; FREQUENCY OF CHANGE **TIMES** DISPENSING FREQUENCY. ADDITIONALLY THE PATIENT IS COMPETENT, HAS BEEN INSTRUCTED ON PROPER USE AND SHOULD NOT USE MORE THAN ONE DRESSING PER DAY, PER EACH PRIMARY AND/OR SECONDARY DRESSING(S) ORDERED.

(SECTION 4) AUTHORIZATIONS AND SIGNATURES

PROVIDER'S NAME: _____

NPI: _____

SIGNATURE: _____ ____/____/____ ***(DATE)***

VERBAL ORDER: ☐ ***YES*** ☐ ***NO***

(IF YES, PLEASE LIST THE ASSISTING CASE MANAGER BELOW)

CASE MANAGER ASSISTING WITH VERBAL ORDER:

_____ ***(PRINT NAME)***

SUPPLIER SIGNATURE: _____ ____/____/____ ***(DATE)***

(SECTION 5) COORDINATION OF CARE

I ATTEST THAT I AM A PROVIDER/CLINICIAN PROVIDING NECESSARY HEALTH CARE TO THE ASSOCIATED PATIENT WHO REQUIRES COORDINATION OF CARE AND PRISM HAS THE AUTHORITY TO COORDINATE CARE ON BEHALF OF MY PATIENT. FURTHERMORE THE PATIENT HAS CHOSEN PRISM TO ASSIST IN PROVIDING THE REQUESTED CARE BY EITHER; PROVIDING PRODUCT, VERIFYING INSURANCE BENEFITS, BILLING FOR SERVICE OR COORDINATING CARE FOR THE ASSOCIATED PATIENT SHOULD DIRECT SERVICE NOT BE AN OPTION.

PROVIDER/CLINICIAN COORDINATING CARE:

_____ ***(PRINT NAME)***

CLINICIAN SIGNATURE: _____ ____/____/____ ***(DATE)***