WOUND CARE DISPENSING ORDER FORM

Phone: (800) 796-3533 | Fax: (931) 796-1718

REFERRING FACILITY

NAME: _____

CITY: _____ STATE: _____

PHONE: _____ FAX: _____

PATIENT INFORMATION

NAME: _____

RX DATE: _____ DATE OF BIRTH: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ FAX: _____

PRI. INS.: _____ POLICY NO.: _____

SEC. INS.: _____ POLICY NO.: _____

CORNERSTONE HEALTH SYSTEMS

SPECIFY ORDER TYPE

____ NEW (this order replaces existing orders)

____ ADD (add these products to order on file)

ORDER DETAILS

In what increments would you like the patients order filled? (number of 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 MEASUREMENTS

In inches

	CIRCUMFERENCE		LENGTH*
	ANKLE	CALF	
RIGHT			
LEFT			

* Measure from heel to back of knee

COMPRESSION STOCKING BRAND/TYPE

____ 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			
COLLAGEN W/ SILVER	ANY	30					
COLLAGEN	ANY	30					
CALCIUM ALGINATE W/ SILVER	MOD-HEAVY	30					
CALCIUM ALGINATE	MOD-HEAVY	30					
PETROLATUM EMULSION GAUZE	ANY	30					
HYDROCOLLOID	LIGHT-MOD	12					
HYDROGEL	NONE-LOW	3 oz					
FOAM DRESSING	MOD-HEAVY	12					
FOAM DRESSING W/ BORDER	MOD-HEAVY	12					
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					
TAPE SIZE:_____	ANY	2 rolls					
OTHER							

CASE MANAGER

_____

ORDERING PHYSICIAN

NAME: _____ NPI NO.: _____

SIGNATURE: _____ DATE: _____