Wound Care Prescription Form

R&M REYES ENTERPRISE

Phone: 676-7661
Fax: (808) 380-2893

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:	

What is this patient's expected duration of need? ***(Days)*** 30 60 90

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

DRESSINGS Indicate Size	REQUIRED DRAINAGE	MAX UNITS PER MONTH	FREQUENCY OF CHANGE	WOUND NUMBER 1	2	3	4
MEDIHONEY CAL	ANY	30					
	ANY	30					
	MOD-HEAVY	30					
CALCIUM ALGINATE Rope__ length__	MOD-HEAVY	30					
XEROFORM size?	ANY	30					
GAUZE IMPREGNATED 3"x3", 3"x8"	ANY	30					
HYDROGEL 2"x2", 4"x4", __oz	NONE-LOW	3 OZ					
	MOD-HEAVY	12					
FOAM DRESSING W/ BORDER	MOD-HEAVY	12					
ABD PAD 5"x9", 8"x10"	MOD-HEAVY	30					
HYDROCOLLOID 4"x4", 6"x6", 8"x8"	LIGHT/MOD	12					
CONFORMING ROLL GAUZE size?	ANY	30					
STERILE GAUZE 2X2 4X4	ANY	100					
ANTIMICROBIAL GAUZE SPONGE	ANY	30					
TAPE 1" or 2"	ANY	2 ROLLS					
PACKING STRIPS ¼", ½",1"							

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

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

	COMPRESSION STOCKINGS

WOUND ASSESSMENT

WOUND	ICD-10 CODES & DESCRIPTION *(e.g. E10.621 diabetes mellitus w/ foot 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

	PROVIDER'S SIGNATURE
	NPI #
DATE	
SIGNATURE	X

PROVIDER'S APPROVAL

I certify that I am the physician identified on this form. I have reviewed the Rx Form. Any Statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity info is true, accurate and complete to the best of my knowledge. I certify that the patient/caregiver is capable and has successfully completed training or will be trained on the proper use of the products prescribed on this Written Order. The patient's record contains supporting documentation that substantiates the utilization and medical necessity of the products listed and physician notes will be provided to R&M Reyes upon request. I understand any falsification, omission or concealment of material fact in that section may subject me to civil or criminal liability. A copy of this order will be retained as part of patients medical record.

PRINT NAME	X

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