Physician's Written Order

Wound Care Supplies

1810 Summit Commerce Park
Twinsburg, OH 44087
p 1-800-321-0591 **f** 330-963-6172
w www.edgepark.com

All fields are required to process an order.

Patient

First: ________ **Last** ________ **MI** ________ **Patient DOB:** ____/____/____ **Gender** ☐ **M** ☐ **F**
Address: ________ **Phone #:** ________
City: ________ **State:** ____ **ZIP:** ________ **E-mail Address:** ________

Doctor

Prescribing Physician Name: ________
Street Address: ________
City: ________ **State:** ____ **Zip:** ________
Phone: ________ **Fax:** ________
NPI #: ________

Facility

Nurse Name: ________
Facility: ________
Phone #: ________

Insurance

Primary Insurance: ________
Policy/ID #: ________
Group #: ________
Phone #: ________
Secondary Insurance: ________
Policy/ID #: ________
Group #: ________
Phone #: ________

Diagnosis

Reason for Use of Dressings
☐ **Surgical** ☐ **Ulcer** ☐ **Other:** ________

Is patient allergic to Latex? ☐ **Yes** ☐ **No**
Is patient on Home Health? ☐ **Yes** ☐ **No**

Wound 1 **Location:** ________ **ICD.9 Stage** ________ **Dimensions (cm)** ____ L ____ W ____ D
Debridement ☐ **No** ☐ **Yes** **Type:** ________ **Exudate** ☐ **None** ☐ **Light** ☐ **Moderate** ☐ **Heavy**
Thickness ☐ **Partial** ☐ **Full** **Duration of Treatment** ☐ **15 days** ☐ **30 days** **Freq. of Change** ________ **day/** ________ **week**

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Products

Dressing	Size/Type	Brand	Dressing Type	Units per Change	Wound#
Alginate	☐ 2″ x 2″ ☐ 4″ x 4″ ☐ Other: ________ ☐ 2″ x 2″ ☐ 4″ x 4″ ☐ Other: ________ ☐ Rope ☐ ________ length (per 6″)		☐ Prim. ☐ Sec.		
Collagen	☐ 2″ x 2″ ☐ 4″ x 4″ ☐ 4.1 sq. in. ☐ Other: ________		☐ Prim. ☐ Sec.		
Composite	☐ 2″ x 2″ ☐ 4″ x 4″ ☐ 6″ x 8″ ☐ Other: ________		☐ Prim. ☐ Sec.		
Foam	☐ 3″ x 3″ ☐ 4″ x 4″ ☐ 6″ x 6″ ☐ Other: ________ ☐ Adhesive Border		☐ Prim. ☐ Sec.		
Gauze Impregnated	☐ 2" x 2" ☐ Hydrogel	AMERIGEL	☐ Prim. ☐ Sec.		
Hydrocolloid	☐ 4″ x 4″ ☐ 6″ x 6″ ☐ 8″ x 8″ ☐ Other: ________ ☐ Adhesive Border ☐ Wound Filler ________ oz.		☐ Prim. ☐ Sec.		
Hydrogel	☐ Wound Filler ________ oz. ☐ Other ________	AMERIGEL	☐ Prim. ☐ Sec.		
Transparent Film	☐ 2 3⁄8″ x 2 3⁄4″ ☐ 4″ x 4 3⁄4″ ☐ 6″ x 86″ ☐ Other: ________		☐ Prim. ☐ Sec.		
ABD Pads	☐ 5″ x 9″ ☐ 8″ x 7.5″ ☐ 8″ x 10″ ☐ Other: ________		☐ Prim. ☐ Sec.		
Gauze Sponge	☐ 2″ x 2″ ☐ 4″ x 4″ ☐ 8″ x 10″ ☐ Other: ________ ☐ Sterile		☐ Prim. ☐ Sec.		
Packing Strips	☐ 1⁄4″ ☐ 1⁄2″ ☐ 1″ ☐ Other: ________ ☐ Plain ☐ Idoform		☐ Prim. ☐ Sec.		
Tape	☐ 1″ ☐ 2″ ☐ Other: ________ ☐ Paper ☐ Cloth ☐ Other: ________		☐ Prim. ☐ Sec.		
Gloves	☐ S ☐ M ☐ L ☐ XL ☐ Latex ☐ Vinyl ☐ Powder Free		☐ Prim. ☐ Sec.		
AMD	☐ Hydrogel Wound Filler ☐ Hydrogel 2"x 2" Impregnated Gauze	AMERIGEL	☐ Prim. ☐ Sec.		
Other	☐		☐ Prim. ☐ Sec.		
Other	☐		☐ Prim. ☐ Sec.		
Other	☐		☐ Prim. ☐ Sec.		

I certify that I am the physician identified on this form. I have reviewed the Physician's Written Order. Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information 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 and other supporting documentation will be provided to Edgepark 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 the patient's medical record.

Physician Signature: ________ Date: ________
(Stamps are not acceptable)

Printed Name: ________

This fax message and any attachments may contain confidential information. If you are not the intended recipient and have received this message in error, please inform sender and delete the contents without copying, distributing or forwarding.
By faxing this form you are acknowledging that the patient is aware that an Edgepark Representative may be contacting them for any additional information to process this order. Thank you.