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WOUND CARE QUICK START FORM

T 1-800-451-6510 F 1-800-749-0711

(To receive a Fax Confirmation, fax to: 1-866-368-2629)

PATIENT INFORMATION

Please complete all patient information below or list the patient name, date of birth and attach face sheet containing the demographic information.

Patient Name ____________________

❑ Male ❑ Female Date of Birth ____________________

Address ____________________

City ____________________ State __________ Zip __________

Tel ____________________ ❑ Patient has been notified of order

Email ____________________

Resp/Emerg Contact ____________________ Tel ____________________

Patient's Preferred Language ❑ English ❑ Spanish ❑ Other __________

Is patient being seen by Home Health Agency? ❑ Yes ❑ No

INSURANCE INFORMATION

Primary Ins Co ____________________

ID# ____________________ Tel ____________________

Secondary Ins Co ____________________

ID# ____________________ Tel ____________________

REFERRAL INFORMATION

Referral Number ____________________

Referral ____________________

Contact ____________________ Tel ____________________

How would you prefer to be contacted:

❑ Phone ____________________

❑ Email ____________________

❑ Fax ____________________

DIAGNOSIS ____________________

WOUND INFORMATION

	WOUND #1	WOUND #2	WOUND #3
Wound Type			
Location	❑ LT ❑ RT __________	❑ LT ❑ RT __________	❑ LT ❑ RT __________
Length X Width X Depth	X X	X X	X X
Stage/Thickness	❑ II ❑ III ❑ IV ❑ Partial ❑ Full	❑ II ❑ III ❑ IV ❑ Partial ❑ Full	❑ II ❑ III ❑ IV ❑ Partial ❑ Full
Drainage Amount	❑ Dry ❑ Min ❑ Mod ❑ Hvy	❑ Dry ❑ Min ❑ Mod ❑ Hvy	❑ Dry ❑ Min ❑ Mod ❑ Hvy
Frequency of Change			
Is Wound Debrided/Surgically Created?	❑ Yes ❑ No	❑ Yes ❑ No	❑ Yes ❑ No
Additional Wound Information			

PRODUCTS

Use "✓" to indicate primary and secondary dressings for each wound. One dressing per change unless noted otherwise.

PRIMARY DRESSING					WND#1	WND#2	WND#3
Collagen	2x2	4x4					
Collagen with Silver	2x2	4x4					
Calcium Alginate	2x2	4x4	4x8	Rope			
Silver Alginate	2x2	4x5	Rope				
AmeriGel Hydrogel	1 oz tube	(3) 1 oz tubes					
AmeriGel Satr. Gauze	2x2						
Hydrocolloids Thick/Thin	2x2	4x4	6x6				
Other							
Cleansing Pack (Gauze, Saline, Gloves) – NEW PATIENTS ONLY ❑							

SECONDARY DRESSING				WND#1	WND#2	WND#3
ABD	5x9	8x7.5	8x10			
Foam	2x2	4x4	4x8			
Bordered Foam	2x2 pad	4x4 pad	4x6 pad			
Composite	2x2 pad	4x4 pad	4x6 pad			
Bordered Gauze	2x2 pad	4x4 pad	4x6 pad			
Kerlix	3"	4" (AMD ❑)				
Roll Gauze Conform	2"	3"	4" (AMD ❑)			
Cloth Tape	1"	2"				
Medipore Tape	2"	4"				
Other						

MEDICARE PATIENT REFILL ORDER CONFIRMATION: I understand that National Rehab (NR) will be providing me with the products ordered by my physician on this Quick Start form. The amount of supplies I have remaining from my last supply order are as follows: *(Please list each product that you have remaining and the number of days that each of those products would last):*

____

____

PATIENT SIGNATURE ____________________ **DATE** ____________________

BY SIGNING BELOW, I *(Physician)* **AUTHORIZE the use of this document as a physician order, and I certify that the above prescribed supplies are medically necessary and reasonable. I will maintain an original signed copy of this order in my medical records.**

Ordering Physician **(Please Print)** ____________________

Address ____________________ Tel ____________________ Fax ____________________

Physician Signature ____________________ Date __________ NPI# ____________________

PRESCRIPTION VALID FOR: ❑ 30 days ❑ 60 days ❑ 90 days ***START DATE*** _____/_____/_____ ***DISPENSE:*** ❑ 30 day supply ❑ 2 week supply

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