

Wound Care Prescription Form (REFILLS _____)

PATIENT/FACILITY INFORMATION

Patient Name: _____ D.O.B. _____
Facility Name: _____
Facility City/State: _____
Facility Phone: _____
Facility Fax: _____
Case Manager: _____

PRESCRIPTION INFORMATION

Prescription Date: _____
Order Type: ☐ NEW (Replace existing) ☐ ADD (Supplement existing)
Frequency: ☐ 15 DAYS ☐ 30 DAYS (Default if not specified)
Does patient have Diabetes? ☐ YES ☐ NO
Patient being seen by Home Health Services? ☐ YES ☐ NO
Patient trained to apply requested dressings? ☐ YES ☐ NO

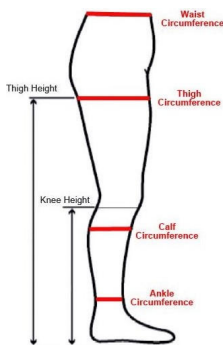
COMPRESSION STOCKINGS (Must have open venous ulcer to qualify)

Compression: ☐ 20-30mmHg ☐ 30-40mmHg ☐ 40-50mmHg
Leg Side: ☐ Left Leg ☐ Right Leg
Toe Type: ☐ Open Toe ☐ Closed Toe
Color: ☐ Black ☐ Beige

ICD-10: _____

LEG CIRCUMFERENCE:

Waist: _____ (cm)
Left Thigh: _____ (cm) Right Thigh: _____ (cm)
Left Calf: _____ (cm) Right Calf: _____ (cm)
Left Ankle: _____ (cm) Right Ankle: _____ (cm)



LEG LENGTH (THIGH) (Heel to back of thigh): _____ (cm)

LEG LENGTH (KNEE) (Heel to back of knee): _____ (cm)

WOUND CARE PRODUCTS

PRODUCT TYPE	CHANGE FREQ.	WOUND NUMBER			
		1	2	3	4
Collagen w/ Silver					
Collagen					
Calcium Alginate w/ Silver	Daily				
Calcium Alginate	Daily				
Hydrocolloid	Every 3 Days				
Hydrogel Tube					
Foam Dressing	Every 3 Days				
Foam Dressing w/ Border	Every 3 Days				
Foam Dressing w/ Silver	Every 3 Days				
ABD Pad	Daily				
Antimicrobial Gauze Sponge	Daily				
Conforming Roll Gauze	Daily				
Gauze ☐ 2" x 2" ☐ 4" x 4"	Daily				
Sterile Gauze ☐ 2" x 2" ☐ 4" x 4"	Daily				
Tape (Size: _____)	Daily				
Nitrile Gloves ☐ SM ☐ MD ☐ LG					
Other:					

WOUND ASSESSMENT

WOUND	ICD-10	DATE OCCURRED	CHANGE FREQ.	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 APPROVAL

I attest by my signature that it is my intention for this prescription to remain valid until the underlying disease/diagnosis described above is resolved or otherwise directed by the signer.

NPI#: _____ Date: _____

PRINT NAME: _____

SIGNATURE: _____

PATIENT APPROVAL

I request that payment of my insurance benefits be made to STYMCO Medical, LLC for any supplies or services they provide me. I am responsible for any balance due that is not covered by my insurance. I understand that any product received in my home cannot be returned if opened. I authorize any holder of my medical information to release to STYMCO Medical, LLC any information needed to determine benefits payable for these supplies or services.

PATIENT SIGNATURE: _____