SAGE MEDICAL SUPPLY

WOUNDCARE ORDER FORM

Phone: 484.364.3039 • Fax: 610.471.0791

IN ORDER TO PROCESS FAX DEMOGRAPHICS AND ASSESSMENT RECORD WITH THIS COMPLETED FORM.

Patient Information

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

Name: _____ ❑ Male ❑ Female DOB: _____/_____/_____

Address: _____ City: _____ State: _____ Zip:_____

Phone: _____ Email: _____

Emergency Contact: _____ Phone: _____

Insurance Company: _____ Insurance # _____ RX Date: _____/_____/_____

In what increments would you like the patients order filled? ❑ 15 days ❑ 30 days Is this patient currently being seen by Home Health Services? ❑ Yes ❑ No

Patient's order will be filled 30 day increments if not otherwise indicated

Have the patient's wound(s) ever been debrided? ❑ Yes ❑ No

PRODUCT INFORMATION

COMPRESSION GARMENTS
PLEASE SELECT COMPRESSION LEVEL

❑ 30-40 mmHg ❑ 40-50 mmHg

LEG MEASUREMENTS
(Circumference of ankle and calf. Length from the back of knee to the heel)

In Inches	ANKLE	CALF	LENGTH
RIGHT			
LEFT			

PLEASE SELECT GARMENT TYPE(S)

Gradient Compression Stockings

❑ Single Layer

❑ Dual Layer

❑ Medi Dual Layer

❑ Other:

Gradient Compression Wrap:

❑ Juxta Lite

❑ Other:

DRESSINGS	REQUIRED DRAINAGE	FREQUENCY OF CHANGE	WOUND NUMBER 1	2	3	4
COLLAGEN W/SILVER	ANY					
COLLAGEN	ANY					
CALCIUM ALGINATE W/SILVER	MOD-HEAVY					
CALCIUM ALGINATE	MOD-HEAVY					
HYDROCOLLOID	LIGHT-MOD					
HYDROGEL	NONE-LOW					
FOAM DRESSING	MOD-HEAVY					
FOAM DRESSING W/BORDER	MOD-HEAVY					
ABD PAD	MOD-HEAVY					
ANTIMICROBIAL BULKY ROLL GAUZE	ANY					
CONFORMING ROLL GAUZE	ANY					
STERILE GAUZE ❑ 2X2 ❑ 4X4	ANY					
ANTIMICROBIAL GAUZE SPONGE	ANY					
TAPE SIZE:	ANY					
OTHER:						

PLEASE CHECK ANY MEDICALLY NECESSARY ITEMS THAT SHOULD BE INCLUDED

❑ GLOVES ❑ SKIN PREP ❑ STERILE WATER ❑ COTTON TIP APPLICATORS ❑ ADHESIVE REMOVER

WOUND ASSESSMENT

WOUND	DESCRIPTION *(e.g. diabetic ulcer)*	ICD-10 Diagnosis Code	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

AUTHORIZATIONS

COORDINATION OF CARE: By my signature below I attest that I am a clinician providing medically necessary health care to the associated patient who requires coordination of care and you have authority to coordinate care on behalf of my patient. Furthermore, the patient has chosen Sage Medical Supply to assist in providing the requested care by either; providing product, verifying insurance benefits, billing for service or coordinating care for the associated patient should direct service not be an option.

Name: _____ Position: _____ Date: _____

PROVIDER'S APPROVAL

Print Name: _____

NPI#: _____

Signature*: _____ Date: _____

*I attest by my signature that 1) the requested supplies are medically necessary and 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, 2) the patient has been instructed on the specific use of the requested supplies and is competent to perform dressing changes, and 3) the supplier should size the requested supplies pursuant to the associated Local Coverage Determination for Surgical Dressings.

PATIENT'S APPROVAL

I request that payment of my insurance benefits be made to Sage Medical Supply for any supplies or services they provide me. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home cannot be returned if opened. I authorize any holder of my medical information to release to Sage Medical Supply any information needed to determine benefits payable fore these supplies or services. Further, I authorize Sage Medical Supply to forward my medical records to the medical professionals in my care and/or make copies of said records. Furthermore, my physician has instructed me on the specific use of the requested supplies and I am competent to utilize the supplies as instructed.

Patient's Signature: _____