PRISM MEDICAL PRODUCTS

Wound Care Prescription Form

Phone: (888) 244-6421

Fax: (800) 975-6321

In order to process your patient's order PLEASE fill out every section of the underlying form:

✓	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:	

In what increments would you like the patients order filled? ***(Days)*** 15 30

(Patient's order will be filled in 15 day increments if not otherwise indicated)

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

RX DATE	
PATIENT'S NAME	
STREET ADDRESS	
CITY/STATE/ZIP	
PHONE #	
DATE OF BIRTH	
PRIMARY INS.	
POLICY #	
SECONDARY INS.	
POLICY #	

COMPRESSION STOCKINGS

PATIENT MUST HAVE AN OPEN VENOUS ULCER TO QUALIFY

PLEASE CHECK SELECTIONS

☐ 30-40 mmHg ☐ 40-50 mmHg

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

✓	BRAND/TYPE COMPRESSION STOCKINGS
	CAROLON MULTI-LAYER COMPRESSION SYSTEM
	CIRCAID-JUXTA LITE
	MEDIVEN ULCER KIT - 2 LAYER W/ SILVER
	JUZO DYNAMIC
	MEDIVEN PLUS W/ MEDISILK

DRESSINGS	REQUIRED DRAINAGE	MAX UNITS PER MONTH	FREQUENCY OF CHANGE	WOUND NUMBER 1	2	3	4
COLLAGEN W/ SILVER	ANY	30					
COLLAGEN	ANY	30					
CALCIUM ALGINATE W/ SILVER	MOD-HEAVY	30					
CALCIUM ALGINATE	MOD-HEAVY	30					
PETROLATUM EMULSION GAUZE	ANY	30					
HYDROCOLLOID	LIGHT-MOD	12					
AMERIGEL HYDROGEL	LIGHT-MOD	3 OZ					
FOAM DRESSING	MOD-HEAVY	12					
FOAM DRESSING W/ BORDER	MOD-HEAVY	12					
ABD PAD	MOD-HEAVY	30					
ANTIMICROBIAL BULKY ROLL GAUZE	ANY	30					
CONFORMING ROLL GAUZE	ANY	30					
STERILE GAUZE 2X2 4X4	ANY	100					
AMERIGEL SATR. GAUZE 2X2	LIGHT-MOD	30					
TAPE SIZE:_____	ANY	2 ROLLS					
OTHER:							

WOUND ASSESSMENT

WOUND	ICD9 CODES/DESCRIPTION *(e.g. 707.19 or diabetic 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

CASE MANAGER

PATIENT'S APPROVAL

I request that payment of my insurance benefits be made to Prism Medical Products, L.L.C. 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 Prism Medical Products, L.L.C. any information needed to determine benefits payable for these supplies or services. Further, I authorize Prism Medical Products, L.L.C. to forward my medical records to the medical professionals in my care and/or make copies of said records.

PATIENT'S SIGNATURE **X**

✓	PROVIDERS APPROVAL
	PROVIDER'S NAME
	NPI #
	SIGNATURE *

*** 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.**