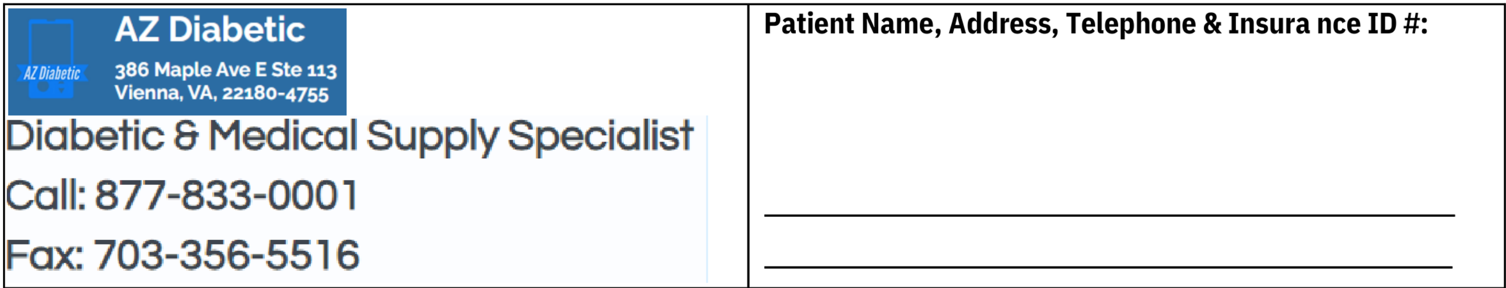
WOUND SUPPLY STANDARD WRITTEN ORDER



Patient Name, Address, Telephone & Insura nce ID #:

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WOUND CARE SUPP LY:

Length of Need (# of months)_____________1-99 (99=life) Date of Last Visit: _________________________________
Diagnosis and Code: ____

Is the wound caused or treated by a surgical procedure? Yes No______ # of wounds
Is debridement of the wound medically necesary? Yes No______ # of wounds
Other type of wound: ____

DAILY SUPPLY

Product Needed: ____ Size:__________________ Frequency of Change:___________
Number to be used at one time: ______________ Is this Primary or Secondary dressing _________________
Is tape required ? Yes No Waterproof tape (ea) _____ Size _____ Non-waterproof tape (ea) ______ Size _____

Product Needed: ____ Size:___________________ Frequency of Change:___________
Number to be used at one time: ______________ Is this Primary or Secondary dressing _________________
Is taperequired ? Yes No Waterproof tape (ea) _____ Size _____ Non-waterproof tape (ea) ______ Size _____

Product Needed: ____ Size:___________________ Frequency of Change:___________
Number to be used at one time: ______________ Is this Primary or Secondary dressing _________________
Is taperequired ? Yes No Waterproof tape (ea) _____ Size _____ Non-waterproof tape (ea) ______ Size _____

Product Needed: ____ Size:___________________ Frequency of Change:___________
Number to be used at one time: ______________ Is this Primary or Secondary dressing _________________
Is tape required ? Yes No Waterproof tape (ea) _____ Size _____ Non-waterproof tape (ea) ______ Size _____

Product Needed: ____ Size:___________________ Frequency of Change:___________
Number to be used at one time: ______________ Is this Primary or Secondary dressing _________________
Is taperequired ? Yes No Waterproof tape (ea) _____ Size _____ Non-waterproof tape (ea) ______ Size _____

PROVIDER CERTIFICATION:

I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.

Provider's Signature: ______________________________________ Date: ____________ NPI: _________________

Provider's Name: ____ Telephone: ____________________________

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