

84-08 37th Ave
Jackson Heights, NY 11372



Tel: (718) 665-3706
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WOUND CARE QUICK START FORM

Patient Name _____ ☐ M ☐ F DOB _____

☐ Patient has been notified of order

PLEASE PROVIDE A FACESHEET WITH PATIENT DEMOGRAPHICS AND MEDICAL RECORDS WITH THE INITIAL ORDER

DIAGNOSIS _____

WOUND INFORMATION

	WOUND #1	WOUND #2	WOUND #3
Wound Type			
Location	<input type="checkbox"/> LT <input type="checkbox"/> RT _____	<input type="checkbox"/> LT <input type="checkbox"/> RT _____	<input type="checkbox"/> LT <input type="checkbox"/> RT _____
Length X Width X Depth	X X	X X	X X
Stage/Thickness	<input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> Partial <input type="checkbox"/> Full	<input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> Partial <input type="checkbox"/> Full	<input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> Partial <input type="checkbox"/> Full
Drainage Amount	<input type="checkbox"/> Dry <input type="checkbox"/> Min <input type="checkbox"/> Mod <input type="checkbox"/> Hvy	<input type="checkbox"/> Dry <input type="checkbox"/> Min <input type="checkbox"/> Mod <input type="checkbox"/> Hvy	<input type="checkbox"/> Dry <input type="checkbox"/> Min <input type="checkbox"/> Mod <input type="checkbox"/> Hvy
Frequency of Change			
Is Wound Debrided/Surgically Created?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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	SECONDARY DRESSING	WND#1	WND#2	WND#3
Collagen 2x2 4x4				ABD 5x9 8x7.5 8x10			
Collagen with Silver 2x2 4x4				Foam 2x2 4x4 4x8			
Calcium Alginate 2x2 4x4 4x8 Rope				Bordered Foam 4x4 (2x2 pad) 6x6 (4x4 pad) 6x8 (4x6 pad)			
Silver Alginate 2x2 4x5 Rope				Composite 4x4 (2x2 pad) 6x6 (4x4 pad) 6x8 (4x6 pad)			
Hydrogel 3 oz tube 2x2 pad 4x4 pad				Bordered Gauze 4x4 (2x2 pad) 6x6 (4x4 pad) 6x8 (4x6 pad)			
Silver Hydrogel 1.5 oz tube 3 oz tube				Kerlix 3" 4"			
Hydrocolloids Thick/Thin 2x2 4x4 6x6				Antimicrobial (AMD) Kerlix 4"			
Gauze 2x2 4x4 4x8				Roll Gauze Conform 2" 3" 4"			
Antimicrobial (AMD) Gauze 2x2 4x4				Antimicrobial (AMD) Roll Gauze Conform 2" 3" 4"			
Other				Cloth Tape 1" 2"			
Other				Medipore Tape 2" 4"			
Other				Other			
Cleansing Pack (Gauze, Saline) - NEW PATIENTS ONLY <input type="checkbox"/>				Other			

I certify that this order is reasonable and medically necessary and not merely a convenience item or it is a mandated benefit. This document may serve as a confirmation of a verbal order and is also written in the patient's record. The foregoing information is true, accurate and complete, I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. **PLEASE KEEP A COPY OF THIS ORDER FOR YOUR PATIENT'S CHART.**

Ordering Physician or Name (Please Print) _____

Address _____ Tel _____ Fax _____

Signature _____ Date _____ NPI# _____

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