PHONE: 800-728-2788
FAX: 866-991-0388
AmericanWoundRX.com

PATIENT INFORMATION	ORDER FACILITY/PROVIDER
PATIENT NAME:	ORDERING PROVIDER:
DATE OF BIRTH:	CASE MANAGER:
PATIENT PHONE:	FACILITY NAME:
START DATE (IF DIFFERENT FROM SIGNATURE DATE):	PHONE:
PATIENT ON HOME HEALTH: ☐ YES ☐ NO	FAX:

Please fill out the entire form COMPLETELY and include the patient's face sheet including insurance information to avoid delays.

DISPENSING FREQUENCY: ☐ 30 DAYS ☐ 15 DAYS LENGTH OF PRESCRIPTION: ☐ 90 DAYS ☐ OTHER: DAYS

WOUND ASSESSMENT INFORMATION

WOUND INFORMATION	WOUND 1	WOUND 2	WOUND 3
WOUND TYPE / DESCRIPTION / ICD10			
LOCATION	☐ LT ☐ RT	☐ LT ☐ RT	☐ LT ☐ RT
SIZE	X X (cm)	X X (cm)	X X (cm)
THICKNESS / STAGE	☐ FULL ☐ PARTIAL ☐ OTHER:	☐ FULL ☐ PARTIAL ☐ OTHER:	☐ FULL ☐ PARTIAL ☐ OTHER:
EXUDATE / DRAINAGE	☐ HEAVY ☐ MOD ☐ LIGHT ☐ NONE	☐ HEAVY ☐ MOD ☐ LIGHT ☐ NONE	☐ HEAVY ☐ MOD ☐ LIGHT ☐ NONE
DEBRIDED DURING TREATMENT OR WOUND SURGICALLY CREATED	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

WOUND CARE PRODUCTS

PRODUCT SELECTION	DRESSING SIZE (Excluding border, if applicable)	LAYER (Primary or Secondary)	FREQUENCY OF CHANGE	SELECT WOUND
CALCIUM ALGINATE DRESSING ☐ AG	☐ 2x2 ☐ 4x5 ☐ 6x6 OTHER:	P or S	☐ DAILY ☐ QOD ☐ OTHER:	☐ 1 ☐ 2 ☐ 3
FOAM DRESSING ☐ AG	☐ 2x2 ☐ 4x5 ☐ 6x6 OTHER:	P or S	☐ DAILY ☐ QOD ☐ OTHER:	☐ 1 ☐ 2 ☐ 3
BORDERED FOAM ☐ AG	☐ 2x2 ☐ 4x4 ☐ 6x6 OTHER:	P or S	☐ DAILY ☐ QOD ☐ OTHER:	☐ 1 ☐ 2 ☐ 3
COLLAGEN DRESSING ☐ AG	☐ 2x2 ☐ 4.3x4.3 OTHER:	P or S	☐ DAILY ☐ QOD ☐ OTHER:	☐ 1 ☐ 2 ☐ 3
HYDROCOLLOID w/BORDER	☐ 2x2 ☐ 4x4 ☐ 6x6 OTHER:	P or S	☐ DAILY ☐ QOD ☐ OTHER:	☐ 1 ☐ 2 ☐ 3
CONTACT LAYER	☐ 4x7 ☐ 8x12 OTHER:	P or S	☐ DAILY ☐ QOD ☐ OTHER:	☐ 1 ☐ 2 ☐ 3
COMPOSITE w/BORDER	☐ 2x2 ☐ 4x4 ☐ 6x6 OTHER:	P or S	☐ DAILY ☐ QOD ☐ OTHER:	☐ 1 ☐ 2 ☐ 3
ABD PAD	☐ 5x9 ☐ 8x10 OTHER:	P or S	☐ DAILY ☐ QOD ☐ OTHER:	☐ 1 ☐ 2 ☐ 3
HONEY MANUKAHD LITE	☐ 2x2 ☐ 4x5	P or S	☐ DAILY ☐ QOD ☐ OTHER:	☐ 1 ☐ 2 ☐ 3
GAUZE BORDERED	☐ 2x2 ☐ 4x4 ☐ 6x6 OTHER:	P or S	☐ DAILY ☐ QOD ☐ OTHER:	☐ 1 ☐ 2 ☐ 3
STERILE GAUZE ☐ AMD	☐ 2x2 ☐ 4x4 ☐ 6x6 OTHER:	P or S	☐ DAILY ☐ QOD ☐ OTHER:	☐ 1 ☐ 2 ☐ 3
KERLIX ☐ AMD	☐ 4.5" OTHER:	P or S	☐ DAILY ☐ QOD ☐ OTHER:	☐ 1 ☐ 2 ☐ 3
KLING ☐ AMD	☐ 2" ☐ 4" OTHER:	P or S	☐ DAILY ☐ QOD ☐ OTHER:	☐ 1 ☐ 2 ☐ 3
TAPE: ☐ CLOTH ☐ PAPER	☐ 1" ☐ 2"		☐ DAILY ☐ QOD ☐ OTHER:	☐ 1 ☐ 2 ☐ 3
		P or S	☐ DAILY ☐ QOD ☐ OTHER:	☐ 1 ☐ 2 ☐ 3
		P or S	☐ DAILY ☐ QOD ☐ OTHER:	☐ 1 ☐ 2 ☐ 3

OTHER ITEMS / NOTES: ADDITIONAL ITEMS: ☐ Saline ☐ Gloves ☐ Cotton Tip Applicators

COMPRESSION STOCKINGS

Side: ☐ Right ☐ Left Color: ☐ Beige ☐ Black	Ankle Calf Length
Open Venous Ulcer: ☐ Yes ☐ No	Right
Class: ☐ Class II 30-40mmHg ☐ Class II 40-50mmHg	Left

Dressing Size: Providers signature indicates the supplier should use the provided wound size(s) to determine appropriate dressing size according to LCD requirements unless noted. **Refills**: Providers signature indicates that number of refills should equal to duraAon of need divided by dispensing frequency. **Quantity**: Providers signature indicates that the quanaty dispensed per order will be the frequency of change Ames the dispensing frequency.

AUTHORIZATION and SIGNATURE

I attest that the items prescribed are reasonable and necessary are documented in the patient record. The patient has selected AWC to provide the requested care. The patient has been instructed on how to use the products prescribed. Additional supporting clinical information will be provided upon request by AWC or by the appropriate insurance payer.

Presciber Printed Name: ____________________

NPI: ____________________

Signature: ____________________ Date: __________