Wound Care Order Form

bedard MEDICAL SUPPLIES
Phone: 207-784-3700

Fax this form and patient records to **207-784-7992**
Also available at **MyBedard.com/referral-forms**

1. Patient Information

Patient Name:______________________________ DOB:__________ Phone #:____________________

Is patient current in a facility? ☐ Y ☐ N If yes, Facility Name:____________________ Facility Phone #:____________________

Is patient receiving home health or outside assistance in the home? ☐ Y ☐ N If yes, Agency Name:____________________

Has patient received any of the below supplies within the last 30 days? ☐ Y ☐ N

2. Wound Assessment & Documentation

	Wound #_______	Wound #_______	Wound #_______	Wound #_______
ICD-10 Code				
Reason for Dressing	☐ Surgical Wound ☐ Debridement - Surgical ☐ Debridement - Mechanical ☐ Debridement - Autolytic ☐ Debridement - Chemical ☐ Other:__________	☐ Surgical Wound ☐ Debridement - Surgical ☐ Debridement - Mechanical ☐ Debridement - Autolytic ☐ Debridement - Chemical ☐ Other:__________	☐ Surgical Wound ☐ Debridement - Surgical ☐ Debridement - Mechanical ☐ Debridement - Autolytic ☐ Debridement - Chemical ☐ Other:__________	☐ Surgical Wound ☐ Debridement - Surgical ☐ Debridement - Mechanical ☐ Debridement - Autolytic ☐ Debridement - Chemical ☐ Other:__________
Wound Type				
Stage	☐ I ☐ II ☐ III ☐ IV ☐ Unstageable ☐ Deep Tissue Injury	☐ I ☐ II ☐ III ☐ IV ☐ Unstageable ☐ Deep Tissue Injury	☐ I ☐ II ☐ III ☐ IV ☐ Unstageable ☐ Deep Tissue Injury	☐ I ☐ II ☐ III ☐ IV ☐ Unstageable ☐ Deep Tissue Injury
Wound Size (LxWxD)	cm	cm	cm	cm
Thickness	☐ Partial ☐ Full	☐ Partial ☐ Full	☐ Partial ☐ Full	☐ Partial ☐ Full
Wound Location	☐ LT ☐ RT	☐ LT ☐ RT	☐ LT ☐ RT	☐ LT ☐ RT
Drainage	☐ None ☐ Light ☐ Mod ☐ Hvy	☐ None ☐ Light ☐ Mod ☐ Hvy	☐ None ☐ Light ☐ Mod ☐ Hvy	☐ None ☐ Light ☐ Mod ☐ Hvy

3. Physician's Order & Authorization

BY SIGNING, I AUTHORIZE the use of this document as an order, and I certify that the below prescribed supplies are medically necessary and reasonable.

Physician Name:______________________________ NPI #:____________________ Phone #:____________________

Adddress:____ Fax #:____________________

Physician Signature:____ Date:____________________

Product	Quantity	# of Refills	Primary / Secondary / Other	Wound #_____ Freq of Change	Wound #_____ Freq of Change	Wound #_____ Freq of Change	Wound #_____ Freq of Change
DRESSINGS							
ABD Pad			☐ Primary ☐ Secondary ☐ Other				
Contact Layer ☐ AG			☐ Primary ☐ Secondary ☐ Other				
Gauze Sponge			☐ Primary ☐ Secondary ☐ Other				
Gauze Roll			☐ Primary ☐ Secondary ☐ Other				
Gelling Fiber ☐ AG			☐ Primary ☐ Secondary ☐ Other				
Hydrocolloid			☐ Primary ☐ Secondary ☐ Other				
Hydrogel Dressing			☐ Primary ☐ Secondary ☐ Other				
Non-Adherent			☐ Primary ☐ Secondary ☐ Other				
Xeroform (Impregnated)			☐ Primary ☐ Secondary ☐ Other				
FOAMS							
Foam ☐ AG			☐ Primary ☐ Secondary ☐ Other				
Bordered Foam ☐ AG			☐ Primary ☐ Secondary ☐ Other				
Sacrum Foam ☐ AG			☐ Primary ☐ Secondary ☐ Other				
ALGINATES							
Antimicrobial Alginate ☐ AG			☐ Primary ☐ Secondary ☐ Other				
Calcium Alginate ☐ AG			☐ Primary ☐ Secondary ☐ Other				
COLLAGENS							
Collagen ☐ AG			☐ Primary ☐ Secondary ☐ Other				
GELS							
Hydrogel Gel ☐ AG			☐ Primary ☐ Secondary ☐ Other				
Medihoney ☐ Gel ☐ Paste			☐ Primary ☐ Secondary ☐ Other				
TAPES							
☐ Type:			☐ Primary ☐ Secondary ☐ Other				
OTHER:			☐ Primary ☐ Secondary ☐ Other				