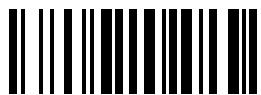


# Wound Care Order Form

Fax this form and patient records to 207-784-7992

Also available at [MyBedard.com/referral-forms](http://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 # _____
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### ICD-10 Code

<b>Reason for Dressing</b>	<input type="checkbox"/> Surgical Wound			
	<input type="checkbox"/> Debridement - Surgical			
	<input type="checkbox"/> Debridement - Mechanical			
	<input type="checkbox"/> Debridement - Autolytic			
	<input type="checkbox"/> Debridement - Chemical			
	<input type="checkbox"/> Other: _____			
<b>Wound Type</b>				
<b>Stage</b>	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> Unstageable <input type="checkbox"/> Deep Tissue Injury	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> Unstageable <input type="checkbox"/> Deep Tissue Injury	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> Unstageable <input type="checkbox"/> Deep Tissue Injury	<input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/> Unstageable <input type="checkbox"/> Deep Tissue Injury
<b>Wound Size (LxWxD)</b>	cm	cm	cm	cm
<b>Thickness</b>	<input type="checkbox"/> Partial <input type="checkbox"/> Full			
<b>Wound Location</b>	<input type="checkbox"/> LT <input type="checkbox"/> RT			
<b>Drainage</b>	<input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Mod <input type="checkbox"/> Hvy	<input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Mod <input type="checkbox"/> Hvy	<input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Mod <input type="checkbox"/> Hvy	<input type="checkbox"/> None <input type="checkbox"/> Light <input type="checkbox"/> Mod <input type="checkbox"/> 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 #: \_\_\_\_\_

Address: \_\_\_\_\_ Fax #: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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