



**PH: 1-888-287-9797**  
**FAX: 1-877-287-2007**

Patient Name \_\_\_\_\_ Date: \_\_\_\_\_

Facility Name \_\_\_\_\_

**PLEASE INCLUDE PATIENT'S PERSONAL AND INSURANCE INFORMATION WITH ORDER**

**It is imperative to determine if a nurse is coming into the home for ANY reason.**  
 Patient is receiving home health OR outside assistance in the home: \_\_\_\_ Yes \_\_\_\_ No

REQUIRED WOUND INFORMATION (circle choices & fill in spaces)												
Wound Stage	Wound 1				Wound 2				Wound 3			
	II	III	IV	P F Un	II	III	IV	P F Un	II	III	IV	P F Un
ICD9 code												
Size	L x W x D											
Location												
Drainage	min mod heavy				min mod heavy				min mod heavy			
Ever debrided?	yes no				yes no				yes no			
Duration of need	15 30 60 90				15 30 60 90				15 30 60 90			
Frequency	qd qod wkly				qd qod wkly				qd qod wkly			

CUSTOMIZED DRESSING ORDERS						
PRODUCT	STYLE	DRAINAGE Requirement	UNITS/MO. Requirement	Wound		
				1	2	3
calcium alginate	2x2, 4x5, ¾ x 12	mod-heavy	up to 30	P S	P S	P S
silver alginate	2x2, 4x5, ¾ x 12	mod-heavy	up to 30	P S	P S	P S
Medihoney alginate	2x2, 4x5, ¾ x 12	mod-heavy	up to 30	P S	P S	P S
Anasept Gel	3 oz. tube	no-min	3 oz	P S	P S	P S
Silver Sept Gel	1.5 oz., 3 oz tube	no-min	3 oz.	P S	P S	P S
Hydrofera Blue	2x2, 4x4	mod-heavy	up to 12	P S	P S	P S
collagen	2x2, 4.34 sq. in.	any	up to 12	P S	P S	P S
non-adherent drsg.	3x3, 3x8	any	up to 30	P S	P S	P S
transparent film	2x3, 4.25x4.25, 6x8	no-min	up to 12	P S	P S	P S
ABD pad	5x9, 8x10	mod-heavy	up to 30	P S	P S	P S
Algidex AG foam	2x2, 4x5	mod-heavy	up to 12	P S	P S	P S
bordered foam	1.6x2, 3x3, 4x4, 6x6	mod-heavy	up to 12	P S	P S	P S
antimicrobial gauze	4" roll	any	up to 30	P S	P S	P S
gauze roll	4" bulky roll	any	up to 30	P S	P S	P S
conforming gz. roll	2" 4"	any	up to 30	P S	P S	P S
antimic. gz sponge	2x2, 4x4	any	up to 30	P S	P S	P S
tape - pap /trans / silk	1" 2" 3"	any	2 rolls/wound	P S	P S	P S
retention tape	2" 4" 6"	any	1 roll/wound	P S	P S	P S

P=primary S=secondary

**Please write in other products or specific brands desired:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**AVAILABLE FOR PURCHASE ONLY - no S&H with order above**

**ANASEPT SPRAY** 8 oz. pump \$11\_\_\_\_ 12 oz. trigger \$14\_\_\_\_

Visa \_\_ MC\_\_ Number \_\_\_\_\_ Exp. \_\_\_\_\_

Card Holder Name \_\_\_\_\_

Billing Address \_\_\_\_\_

\_\_\_\_\_

**Carolon Multi-Layer Compression System**

**Patient must have an open venous ulcer to qualify.**

(circle choices below)

Size: A B C D E F G

Leg: R L Both

Color: Beige Black (F and G beige only)

Class II (30-40 mmHg) Class III (40-50 mmHg)

Ankle Cir	Calf Cir	Length Heel to bend in knee	Size
7" - 8"	10" - 13"	To 15" - short	A
		Over 15" - reg	
8" - 9"	12" - 15"	To 16" - short	B
		Over 16" - reg	
9" - 10"	14" - 17"	To 17" - short	C
		Over 17" - reg	
10" - 11"	16" - 19"	To 18" - short	D
		Over 18" - reg	
11" - 12"	18" - 21"	To 18" - short	E
		Over 18" - reg	
12" - 13"	20" - 23"	To 18" - short	F
		Over 18" - reg	
13" - 14"	22" - 26"	To 18" - short	G
		Over 18" - reg	

If both legs are involved, please measure separately.  
 Circle two sizes if needed.

**Assignment of Benefits**

I request that all payments from any insurance carrier, including Medicare, Medicaid or private insurance company be made on my behalf to Wound Care Resources, Inc. (WCR) for any equipment, supplies or devices provided to me by WCR. I authorize the release of my medical information to HCFA and/or my insurance carrier and its agencies for the purpose of review of healthcare benefits for the determination of payment. This authorization will remain in effect until written notification by my legal representative or me has been received. I have been informed of all copay amounts and am responsible for any balance due not covered by my insurance. I have received a copy of the Supplier Standards and Scope of Service from WCR.

**Patient Rights**

I have been informed of my Patient's Rights to Privacy given me by my Physician's Office:

Patient/Caregiver Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician Name \_\_\_\_\_ NPI# \_\_\_\_\_

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

Physician Phone \_\_\_\_\_