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

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 Over 15" - reg	A
8" – 9"	12" – 15"	To 16" - short Over 16" - reg	B
9" – 10"	14" – 17"	To 17" - short Over 17" - reg	C
10" – 11"	16" – 19"	To 18" - short Over 18" - reg	D
11" – 12"	18" – 21"	To 18" - short Over 18" - reg	E
12" – 13"	20" – 23"	To 18" - short Over 18" - reg	F
13" – 14"	22" – 26"	To 18" - short Over 18" - reg	G

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.

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

REQUIRED WOUND INFORMATION (circle choices & fill in spaces)

	Wound 1	Wound 2	Wound 3
Wound Stage	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	30 60 90	30 60 90	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	Wound 2	Wound 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
DryMax	4x4, 4x8	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	3 oz tube	no-min	3 oz.	P S	P S	P S
Multidex Gel	3 oz tube	no-min	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, 3x8,4x4,5x9	any	up to 30	P S	P S	P S
Hydrodera Blue	2x2 , 6x6	mod-heavy	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	3x3, 4x4, 6x6	mod-heavy	up to 12	P S	P S	P S
antimicrobial gauze	4" bulky roll	any	up to 30	P S	P S	P S
gauze roll ST	4" bulky roll	any	up to 30	P S	P S	P S
conforming stretch gz	2"roll 4"roll	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:

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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 ____

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