Flagship Medical, Inc.

WOUND CARE ORDER FORM

PHONE: 215.992.7770

FLAGSHIPMEDICAL.COM

FAX: 215.992.7782

Patient Name _____ ☐M ☐F DOB _____

☐ ***Patient has been notified of order***

PLEASE PROVIDE A FACESHEET WITH PATIENT DEMOGRAPHICS WITH THE INITIAL ORDER

REFERRAL INFORMATION

Referral Number _____

Referral _____

Contact _____ Tel _____

How would you prefer to be contacted:

❑ Phone _____ ❑ Email _____ ❑ Fax _____

DIAGNOSIS _____

WOUND INFORMATION

	WOUND #1	WOUND #2	WOUND #3
Wound Type			
Location	☐LT ☐RT _____	☐LT ☐RT _____	☐LT ☐RT _____
Length X Width X Depth	X X	X X	X X
Stage/Thickness	☐II ☐III ☐IV ☐Partial ☐Full	☐II ☐III ☐IV ☐Partial ☐Full	☐II ☐III ☐IV ☐Partial ☐Full
Drainage Amount	☐Dry ☐Min ☐Mod ☐Hvy	☐Dry ☐Min ☐Mod ☐Hvy	☐Dry ☐Min ☐Mod ☐Hvy
Frequency of Change			
Is Wound Debrided/Surgically Created?	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Additional Wound Information			

PRODUCTS

Use "X" to indicate primary and secondary dressings for each wound. One dressing per change unless noted otherwise.

PRIMARY DRESSING					WND#1	WND#2	WND#3
Collagen	2x2	4x4					
Collagen with Silver	2x2	4x4					
Calcium Alginate	2x2	4x4	4x8	Rope			
Silver Alginate	2x2	4x5	Rope				
Hydrogel	3 oz tube	2x2 pad	4x4 pad				
Silver Hydrogel	1.5 oz tube	3 oz tube					
Hydrocolloids Thick/Thin	2x2	4x4	6x6				
Gauze	2x2	4x4	4x8				
Antimicrobial (AMD) Gauze	2x2	4x4					
Other							
Other							
Other							
Cleansing Pack (Gauze, Saline, Gloves) – ***NEW PATIENTS ONLY*** ☐							

SECONDARY DRESSING				WND#1	WND#2	WND#3
ABD	5x9	8x7.5	8x10			
Foam	2x2	4x4	4x8			
Bordered Foam	4x4 (2x2 pad)	6x6 (4x4 pad)	6x8 (4x6 pad)			
Composite	4x4 (2x2 pad)	6x6 (4x4 pad)	6x8 (4x6 pad)			
Bordered Gauze	4x4 (2x2 pad)	6x6 (4x4 pad)	6x8 (4x6 pad)			
Kerlix	3"	4"				
Antimicrobial (AMD) Kerlix	4"					
Roll Gauze Conform	2"	3"	4"			
Antimicrobial (AMD) Roll Gauze Conform	2"	3"	4"			
Cloth Tape	1"	2"				
Medipore Tape	2"	4"				
Other						
Other						

Practice Name: _____ Fax: _____

Address: _____ Phone: _____

Physician's Name: _____ NPI#: _____

Ordering Physician or Licensed Prescriber *(Please Print)* _____

Address: _____ Tel _____ Fax _____

Signature* _____ Date _____ NPI# _____

PRESCRIPTION VALID FOR: ☐ 30 days ☐ 60 days ☐ 90 days ***START DATE*** _____/_____/_____ ***DISPENSE:*** ☐30 day supply ☐ 2 week supply

I certify that this order is reasonable and medically necessary and not merely a convenience item or it is a mandated benefit. This document may serve as a confirmation of a verbal order and is also written in the patient's record. The forgoing information is true, accurate and complete, I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. **PLEASE KEEP A COPY OF THIS ORDER FOR YOUR PATIENT'S CHART.**