WOUND SUPPLY STANDARD WRITTEN ORDER

PROCARE HOME MEDICAL

Please fax to:
Anchorage (907) 274-0773
Fairbanks (907) 458-8914
Soldotna (907) 260-3757
Wasilla (907) 357-7883
or email to:
dme@procarehm.com

Patient Name, Address, Telephone & Insurance ID #:

(_____) _____ - _____ Ins ID#: _____

Patient DOB: ____/____/____ Sex: ____ (M/F)

WOUND CARE SUPPLY:

Length of Need (# of months)_____1-99 (99=life) Date of Last Visit: _____
Diagnosis and Code: _____

Is the wound caused or treated by a surgical procedure? ☐ Yes ☐ No _____ # of wounds
Is debridement of the wound medically necesary? ☐ Yes ☐ No _____ # of wounds
Other type of wound: _____

DAILY SUPPLY

Product Needed: _____ Size: _____ Frequency of Change:_____
Number to be used at one time: _____ Is this ☐ Primary or ☐ Secondary dressing _____
Is tape required ? ☐ Yes ☐ No Waterproof tape (ea) _____ Size _____ Non-waterproof tape (ea) _____ Size _____

Product Needed: _____ Size:_____ Frequency of Change:_____
Number to be used at one time: _____ Is this ☐ Primary or ☐ Secondary dressing _____
Is tape required ? ☐ Yes ☐ No Waterproof tape (ea) _____ Size _____ Non-waterproof tape (ea) _____ Size _____

Product Needed: _____ Size:_____ Frequency of Change:_____
Number to be used at one time: _____ Is this ☐ Primary or ☐ Secondary dressing _____
Is taperequired ? ☐ Yes ☐ No Waterproof tape (ea) _____ Size _____ Non-waterproof tape (ea) _____ Size _____

Product Needed: _____ Size:_____ Frequency of Change:_____
Number to be used at one time: _____ Is this ☐ Primary or ☐ Secondary dressing _____
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Product Needed: _____ Size:_____ Frequency of Change:_____
Number to be used at one time: _____ Is this ☐ Primary or ☐ Secondary dressing _____
Is tape required ? ☐ Yes ☐ No Waterproof tape (ea) _____ Size _____ Non-waterproof tape (ea) _____ Size _____

PROVIDER CERTIFICATION:

I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.

Provider's Signature: _____ Date: _____ NPI: _____

Provider's Name: _____ Telephone: _____