

Physician Order - Wound Care

Patient Information	
Name _____	Date of Birth _____
<input type="checkbox"/> Please attach Facesheet with Insurance Information	

Ordered By _____ Phone (_____) _____

Facility Name _____ Fax (_____) _____

Duration of need (mths) 1 2 3 Other _____

Reason for use of dressing

Surgical wound Date _____ Autolytic debridement (most healing)

Sharp debridement Date _____ Enzymatic debridement

Other: _____

Diagnosis Codes (ICD.9) : _____

Wound #	Location of wound	Type of wound or ICD.9	Thickness		Dimension (cm's)			Drainage			
			Partial	Full	Length	Width	Depth	None	Light	Mod	Heavy
1	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Wnd #	HCPC Code	Type of Dressing	Dressing Size	# used per change	Frequency of change	Days Supply
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> 15 <input type="checkbox"/> 30
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> 15 <input type="checkbox"/> 30
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> 15 <input type="checkbox"/> 30
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> 15 <input type="checkbox"/> 30
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> 15 <input type="checkbox"/> 30

CONTACT PERSON _____	Phone# _____
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PHYSICIAN SIGNATURE _____	NPI# _____	Date _____
<i>I certify that I am the treating physician identified on this form. I certify that the medical necessity form is true, accurate and complete to the best of my knowledge.</i>		