COMPRESSION CARE

PLEASE FAX OR E-MAIL THIS FORM AND THE FOLLOWING TO (615) 807-3334 OR REFERRALS@COMPRESSIONCARE.COM

☐ FACE SHEET ☐ INSURANCE CARD IMAGES ☐ OFFICE NOTES ☐ ANY ADDITIONAL INSTRUCTIONS

PLEASE CALL OR TEXT (615) 583-2273 FOR IMMEDIATE ASSISTANCE COMPLETING THIS FORM

Rx & Certificate of Medical Necessity for Wound Care

PATIENT INFORMATION

First Name Last Name	Order Date	
Phone	Date of Birth	Gender ☐ Male ☐ Female
Email		
Duration **3 Months Unless Otherwise Indicated**	**Frequency of Change & Duration of Need will be Used to Assess Qty to be Dispensed**	

WOUND ASSESSMENT

Wound(s) *Location (Be Specific)*	**Days Supply** *15 30*	**Diagnosis** *ICD 10*	**Dimensions (CM)** *Length Width Depth*	**Drainage** *Dry Lit Mod Hvy*	**Thickness** *Part Full*	**Debrided** *Date*
W1 ☐ LT ☐ RT	☐ ☐		_____ _____ _____	☐ ☐ ☐ ☐	☐ ☐	___/___/___
W2 ☐ LT ☐ RT	☐ ☐		_____ _____ _____	☐ ☐ ☐ ☐	☐ ☐	___/___/___
W3 ☐ LT ☐ RT	☐ ☐		_____ _____ _____	☐ ☐ ☐ ☐	☐ ☐	___/___/___

WOUND CARE SUPPLIES

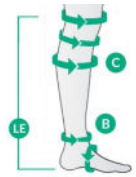
Products *(F) Requires Full Thickness*	**Ag**	**Change Frequency**	**Wound Number** 1	2	3	**Notes**
(F) ABD Pad		Daily	☐	☐	☐	
(F) Alginate	☐	3x/Week	☐	☐	☐	
(F) Collagen	☐	Daily	☐	☐	☐	
Gauze Pads		Daily	☐	☐	☐	
Foam Silicone	☐	3x/Week	☐	☐	☐	
Foam Silicone w/ Border	☐	3x/Week	☐	☐	☐	
Hydrocolloid		3x/Week	☐	☐	☐	
(F) Hydrogel	☐	Daily	☐	☐	☐	
Impregnated Gauze		Daily	☐	☐	☐	
Roll Gauze 4”		Daily	☐	☐	☐	
Super Absorbent Pad		Daily	☐	☐	☐	
			☐	☐	☐	
			☐	☐	☐	
			☐	☐	☐	
Additional Items	☐ Saline ☐ Gloves ☐ Applicators ☐ Skin Prep ☐ Adhesive Remover ☐ Sterile Water					

COMPRESSION GARMENTS

Diagnosis: ☐ I87.2 Chronic Venous Insufficiency WITH Venous Stasis Ulcer(s) in Active Treatment (Must Also be Specified in Patient Records Provided by Physician)

Compression (mmHg): LT: ☐ 30-40 ☐ 40-50 **RT:** ☐ 30-40 ☐ 40-50

MEASUREMENTS (CM)



	Left	**Right**
Calf (C)		
Ankle (B)		
Length (LE)		

GARMENTS & QUANTITY (PER AFFECTED BODY PART)

Including Accessories as Necessary	**Left**	**Right**
☐ Lower Leg Wrap (Light/Heavy)	3 / 3	3 / 3
☐ Knee High Circular Knit Stocking	3	3
☐ Nighttime Compression Garment	2	2
☐ Full Leg Wrap	3	3
☐ Thigh High Circular Knit Stocking	3	3
☐ Ankle Foot Wrap	3	3
☐ Pneumatic Pump & Garment(s)	1	1

☐ **Care Coordination:** The patient has agreed to work with Compression Care and its affiliates, including coordinating care with another provider if necessary.

☐ **Supply Assessment:** The patient does not currently have any of these requested products at home, unless otherwise specified (specify types and quantities of products).

PHYSICIAN AUTHORIZATION

Practitioner Name / Facility	Phone / Fax
Practitioner Email	
Referring Physician Name	Phone / Fax
► **Physician Signature**	
NPI	Date