HOME CARE DELIVERED®
Your Trusted Partner for Medical Supplies

Phone: **(866) 482-4944**
Fax: **(888) 565-4411**
Email: **Refer@HCD.com**
Online: **HCD.com/Refer**

Wound Care Order Form

Please make sure all sections are filled out and include patient demographics to ensure no delays.

STEP 1

Facility Name: ______________________________ Phone: ______________
Facility Fax: ______________ Clinician Name: ______________________________

Doctor / Prescriber:

Name: ______________________ NPI: ____________ Name: ______________________ NPI: ____________

By my signature below, I confirm that the patient has the medical condition(s) listed and is being treated by me. All the information contained on this Physician's Order accurately reflects the patient's medical condition(s) and the treatment regimen that I have prescribed. The medical records for this patient substantiate the prescribed treatment plan. The patient/caregiver is able to use the prescribed product(s) listed above. For Medicare, Medicaid, or other insurance requirements, I will maintain this signed original document in the patient's medical record file for post-payment review/audit purposes.

Signature → Physician Signature : ______________________________ Date: _____/_____/_____

STEP 2

Patient Information:

Please complete all patient information below and or attach a demographics page.

Patient Name: ______________________________ Gender: ☐ M ☐ F DOB: _____/_____/_____
Phone: ______________________ Alternate Phone: ______________________
Address: ______________________ City: ______________ State: _____ Zip: _______
Patient's Insurance Plan Name (Primary): ______________________ ID Number: ______________
Patient's Insurance Plan Name (Secondary): ______________________ ID Number: ______________

STEP 3

Is the Patient currently being seen by Home Health or Hospice? ☐ Yes ☐ No
Authorizations: The patient is requesting coordination of care: ☐ Yes ☐ No

The patient has chosen Home Care Delivered to assist in providing the requested care by either providing product, verifying insurance benefits, billing for services, or coordinating care should direct service not be an option.

STEP 4

Wound Assessment Data:

	Wound #1	Wound #2	Wound #3
Date Assessed			
Wound Location			
ICD.10 / Description			
Drainage	☐ light ☐ mod ☐ heavy	☐ light ☐ mod ☐ heavy	☐ light ☐ mod ☐ heavy
Thickness	☐ Partial ☐ Full	☐ Partial ☐ Full	☐ Partial ☐ Full
Size (length, width, depth)	L= W= D=	L= W= D=	L= W= D=
Has wound ever been debrided?	☐ Yes, Date ___/___/___ ☐ No	☐ Yes, Date ___/___/___ ☐ No	☐ Yes, Date ___/___/___ ☐ No

STEP 5

Please Check the Appropriate Product, Size and Wound:

Please select quantity: ☐ 15 Day Supply ☐ 30 Day Supply

Products / Brand		Size	Change Freq. (Daily, 3/week)	Wound #1	Wound #2	Wound #3
Alginate:	☐ AG	☐ 2x2 ☐ 4x4 ☐ 6x6 ☐ 4x8	Daily	☐	☐	☐
Collagen:	☐ AG	☐ 2x2 ☐ 4x4 ☐ 7x7 ☐ 8x8 ☐ 1 gram (powder)	Daily	☐	☐	☐
Foam:	☐ AG	☐ 2x2 ☐ 3x3 ☐ 4x4 ☐ 4x5 ☐ 6x6 ☐ 4x8 ☐ 8x8 ☐ Sacral	3/week	☐	☐	☐
Border Foam:	☐ AG	☐ 2x2 ☐ 3x3 ☐ 4x4 ☐ 4x5 ☐ 6x6 ☐ 4x8 ☐ 8x8 ☐ Sacral	3/week	☐	☐	☐
Super Absorber:		☐ 3x3 ☐ 4x4 ☐ 6x10	Daily	☐	☐	☐
ABD Pad:		☐ 3x4 ☐ 4x5 ☐ 5x9 ☐ 6x9 ☐ 8x10	Daily	☐	☐	☐
Hydrocolloid:		☐ 4x4 ☐ 6x6	3/week	☐	☐	☐
Conforming Bandage:		☐ 2-inch ☐ 3-inch ☐ 4-inch	Daily	☐	☐	☐
Roll Gauze:	☐ Non-Strl	☐ 2-inch ☐ 3-inch ☐ 4-inch	Daily	☐	☐	☐
Gauze Pad:		☐ 2x2 ☐ 4x4	Daily	☐	☐	☐
Tape Rolls:	☐ Paper ☐ Waterproof	☐ 2-inch ☐ 3-inch	2 Rolls	☐	☐	☐
Contact Layer:	☐ AG	☐ 2x2 ☐ 2x3 ☐ 4x4 ☐ 4x5 ☐ 4x7 ☐ 5x6	1/week	☐	☐	☐
Other:				☐	☐	☐

Compression:

Compression Measurements			
Leg (CM's)	Ankle	Calf	Length
Right			
Left			

Size
☐ S ☐ M ☐ L ☐ XL ☐ XXL

Length
☐ Short ☐ Long

Compression Level
☐ 30-40 mmHg
☐ 40-50 mmHg

Compression Wrap
☐ Juxtalite ☐ Juxtalite HD
☐ Farrow Wrap
☐ Other:

Is there an active Venous Ulcer ☐ Yes ☐ No

Additional Notes:

HCD Field Sales Account Representative: ______________________ Contact Number: ____________ Email: ______________