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: _____
☐ 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: _____