



WOUND CARE PATIENT ENROLLMENT FORM

Fax: (888) 565-4411
or Call: (800) 565-6167

Please note: Before completing and submitting this form to Home Care Delivered, Inc., please make certain that the patient is aware that you have contacted a DME supplier about his/her medical supply order.

Patient Name: _____ Date of Birth: _____ Gender: M / F

Patient Phone #: () _____ Alternate Contact: _____ Alternate Phone #: () _____

Address: _____ City: _____ State: _____ Zip Code: _____

Medicare #: _____ Social Security #: _____

Medicaid #: _____ Secondary Insurance: _____

Language: English Spanish Other:

Physician Name: _____ NPI #: _____ Referred by: _____

Phone #: () _____ Fax #: _____ Organization: _____

Is this patient currently being seen by a Home Health Agency?
 Yes No Discharge Date? _____ Phone #: () _____

Is this patient currently in Hospice? Yes No

Supplies

	Wound 1	Wound 2	Wound 3
Location:			
Type of wound: (i.e. pressure, venous stasis, surgical)			
Color of wound			
Has the wound been debrided? (circle one)	yes no	yes no	yes no
Stage (if pressure ulcer) (circle one) or Thickness (other wound types)	II III IV Partial Full Thickness	II III IV Partial Full Thickness	II III IV Partial Full Thickness
Size in cm: (L x W x D)	___ cm X ___ cm X ___ cm	___ cm X ___ cm X ___ cm	___ cm X ___ cm X ___ cm
Frequency of dressing change			
Exudate (circle one):	Light Moderate Heavy	Light Moderate Heavy	Light Moderate Heavy
Dressing (Please circle requested size)	Primary Secondary	Primary Secondary	Primary Secondary
Gauze, Sterile (2 units/package) 2 x 2 4 x 4	pks/month pks/month	pks/month pks/month	pks/month pks/month
ABD Pads 5 x 9 8 x 10	pks/month pks/month	pks/month pks/month	pks/month pks/month
Conform Bandage Roll 3" width	rolls/month rolls/month	rolls/month rolls/month	rolls/month rolls/month
Kerlix™ Rolled Gauze 4.5" width	rolls/month rolls/month	rolls/month rolls/month	rolls/month rolls/month
Micropore™ Paper Tape 1" 2"	rolls/month	rolls/month	rolls/month
Waterproof Fixation Cloth Tape 2"	rolls/month	rolls/month	rolls/month
Alginate 2 x 2 4 x 4	/month	/month	/month
Silver Alginate 2 x 2 4 x 4.7	/month	/month	/month
Alginate Rope / Silver Alginate Rope .75" x 12"	/month	/month	/month
Non-Adherent Oil Emulsion Dressing 3 x 3	/month	/month	/month
Foam 3 x 3 4 x 4	/month	/month	/month
Adhesive Foam 5 x 5	/month	/month	/month
Hydrocolloid 4 x 4	/month	/month	/month
Hydrogel 3 oz. tube	tube/month	tube/month	tube/month

Authorization of Billing / Medical Information Release

I request that payment of my insurance benefits (Medicare, Medicare Supplemental or other) be made to **Home Care Delivered Inc.** for any supplies or services furnished to me by **Home Care Delivered Inc.** I understand that I am responsible to pay all amounts that are not covered by my insurance. I authorize any holder of medical information about me to release to **Home Care Delivered Inc.** any information needed to determine benefits payable for these supplies or services. In addition, I authorize **Home Care Delivered Inc.** to release my medical records to insurers as well as medical professionals. I authorize **Home Care Delivered Inc.** to contact me by telephone, email or mail regarding my medical supplies.

Patient's Signature _____

Date _____ / _____ / _____
MM DD YY

If patient has signed by marking an "x" due to language barriers or physical limitations, the signature and address of the witness should be entered next to the patient's mark. If the patient is unable to sign due to a physical or mental condition, an Authorized Representative of the patient must complete the section below. By signing on behalf of the patient, you acknowledge that you have authority to do so.

Patient Name: (please print) _____

By: Authorized Representative's Signature: _____ Authorized Representative's Name: _____

Relationship to Patient: _____ Physical/Mental Reason patient is unable to sign: _____

Address: _____ City: _____ State: _____ Zip: _____