INTEGRATED HOME CARE SERVICES
WOUND CARE ORDER FORM

For Avmed and Care Plus ACS PHONE # 954-748-1966 FAX # 954-748-3748

For Simply, Devoted, Doctors and MCCI Send to IHCS PHONE # 1-844-215-4264 FAX # 1-844-215-4265

Patient Name: _____DOB: _____

Address: _____ Phone # _____

City: _____ State_____ ZIPCODE_____

Health Plan: _____ Member ID # _____Auth#_____

IF PATIENT UNDER HHA AGENCY NAME: _____PHONE # _____

PRIMARY DIAGNOSIS ON FILE / WOUND LOCATION

ICD-10 CODE_____ Code Description_____

REFILLS: ☐ **3** ☐ **6** **Ordering for** ☐ **30 Days or** ☐ **14 Days** **START DATE: ___/___/_____**

Use "✓" to indicate primary and secondary dressings for each wound. One dressing per change unless supportive documentation is attached. Doctor's orders are required with all forms

PRIMARY DRESSING	QTY	WD1	WD2	WD3
	Ea/BX	X	X	X
Collagen ___2x2 ___4x4				
Collagen with Silver ___2x2 ___4x4				
Calcium Alginate ___2x2 ___4x4 ___Rope				
Silver Alginate ___2x2 ___4x5 ___Rope				
Hydrogel ___tube ___ 4x4 pad				
Silver Hydrogel 1.5 oz tube 3 oz tube				
Hydrocolloids Thick/Thin ___2x2 __4x4				
Hydrocolloids Bordered ___4x4 ___6x6				
Gauze ___2x2 ___4x4				
Gauze N/S ___2x2 ___4x4				
( ) Xeroform ( ) Vaseline Gauze ( ) Adaptic				
Normal saline 100ml				

SECONDARY DRESSING	QTY	WD1	WD2	WD3
	Ea/BX	X	X	X
ABD ___5x9 ___8x10				
Non Adherent Pad/Telfa 3x4 ( ) OTHER:				
Foam ___2x2 ___4x4				
Bordered Foam ___4x4 ___6x6				
Composite ___4x4 ___6x6				
Kerlix/Bandage Roll 4"				
Sofform/kling/conform ___2"___3" ___4"				
( ) Coban ( ) Elastic Bandage				
Cloth Tape ___1" ___ 2" ___ 3"				
Mefix Tape ___2" ___ 4"				
Paper Tape ___1" ___ 2" ___ 3"				
Other				

ADDITIONAL MEDICAL INFORMATION (REQUIRED) PLEASE ATTACH DR ORDERS FOR WOUND SUPPLY

WOUND 1	WOUND 2	WOUND 3
LOCATION: _____	LOCATION_____	LOCATION _____
LENGTH: _____CM	LENGTH_____CM	LENGTH _____CM
WIDTH:_____ CM	WIDTH: _____ _____CM	WIDTH : _____CM
DEPTH: _____CM	DEPTH: _____CM	DEPTH: _____CM

FREQUENCY CHANGE OF DRESSING: ( ) Q ( ) Q.O.D ( ) Q.W.K ( ) OR: _____

IF ADDITIONAL WOUNDS PLEASE ATTACH INFORMATION IN A SEPARATE PAPER

DOCTOR NAME: _____ NPI #_____PHONE#_____

DOCTOR SIGNATURE_____ DATE_____