Comfort & Care MEDICAL

Have patient's wound/s ever been debrided? YES / NO
**(Debridement is required by Medicare)**

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***Please attach face sheet w/ patient demographics & insurance info***

## PATIENT INFORMATION

Patient Name: _____ DOB: _____/_____/_____ Gender: ☐ Male ☐ Female

Language Pref.: ☐ English ☐ Spanish ☐ Other: _____ Is the patient currently using Nutritional Supplements? ☐ YES ☐ NO

Emergency Contact Name/Phone Number: _____

## WOUND ASSESSMENT

| ICD-10 Code | Wound Location | Has the wound ever been debrided? | Length x Width x Depth | Stage/Thickness | Drainage |
|---|---|---|---|---|---|
| 1. | | ☐ YES ☐ NO | | ☐ 2 ☐ 3 ☐ 4 ☐ Partial ☐ Full | ☐ None ☐ Min ☐ Mod ☐ Hvy |
| 2. | | ☐ YES ☐ NO | | ☐ 2 ☐ 3 ☐ 4 ☐ Partial ☐ Full | ☐ None ☐ Min ☐ Mod ☐ Hvy |
| 3. | | ☐ YES ☐ NO | | ☐ 2 ☐ 3 ☐ 4 ☐ Partial ☐ Full | ☐ None ☐ Min ☐ Mod ☐ Hvy |

## PRODUCT SELECTION

| Wound Dressing | | MAX UNITS PER MONTH | Qty | Select Wound (with X) W1 | W2 | W3 |
|---|---|---|---|---|---|---|
| Tritec | ☐ 4x5 ☐ ☐ ☐ | 30 | | | | |
| CoFlex TLC Zinc 2 Layer | ☐ 4" | 30 | | | | |
| CoFlex TLC Calamine | ☐ 3" ☐ 4" ☐ ☐ | 30 | | | | |
| Xeroform Occlusive Petrolatum Gauze | ☐ 2x2 ☐ 4x3 yds ☐ 1"x8 ☐ 5x9 strip | 30 | | | | |
| AGILE | ☐ 2x2 ☐ 4x4 ☐ ☐ | 30 | | | | |
| 3M ADAPTIC Non-Adhering Dress | ☐ 3x3 ☐ 3x8 ☐ 3x16 ☐ 5x9 | 3oz/30 | | | | |
| Telfa "Ouchless" | ☐ 3x8 ☐ 8x10 ☐ | 12 | | | | |
| Foam Dressing w/ Silver | ☐ 4x4 ☐ 4x5 | 12 | | | | |
| ABD Pad | ☐ 5x9 ☐ 8x10 ☐ | 30 | | | | |
| XTRASORB HCS Adhesive | ☐ 3x3 ☐ 6x6 ☐ | 30 | | | | |
| Kerlix AMD Antimicrobial Large Roll | ☐ 4 1/2" x 4 1/8 yd ☐ | 30 | | | | |
| Gauze Pad Antimicrobial | ☐ 4x4 ☐ ☐ | 30 | | | | |
| Kling TwoPress 2 Lite | ☐ 4" ☐ ☐ | 12 | | | | |
| Coban (Cash Only) | ☐ 4" ☐ ☐ | | | | | |
| Foam Dressing w/ Border | ☐ 3x3 ☐ 4x4 ☐ 5x5 (size includes border) | 2 rolls | | | | |
| 3M Medipore H Soft Cloth Surgical Tape | ☐ 1" ☐ 2" ☐ | 30 | | | | |
| MediHoney Gel (Cash Only) | ☐ | | | | | |
| Other: | | | | | | |

**Length of Need: _____ months**
**Dispense Amount *(select one)*: ☐ 15-day ☐ 30-day**

**Has the patient been educated on how to apply the dressings? ☐YES ☐NO**

Cleansing Products* *(Check all that apply)*
Saline 100ml: ☐ 5 ☐ 10 ☐ 15 ☐ Other _____ ☐
Gloves (1 box): ☐ Medium ☐ Large ☐ Vashe Wound Cleanser 8.5oz. (Cash Pay Only)

**These products are not covered by Medicare and/or Medicare Advantage Plans. If the above patient's insurance benefits follow such guidelines, then these supplies will not be shipped unless the patient agrees to purchase them.*

## REFERRAL INFORMATION

Practice Name: _____ Fax: _____
Office Address: _____ Email: _____
Phone: _____ Preferred Method of Contact? ☐ Phone ☐ Fax ☐ Email
Contact Person: _____

Physician Name: _____ NPI#: _____ Phone: (_____)_____-_____ Ext. _____

Physician Signature: _____ Date: _____/_____/_____

*I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed. I certify that my decision to prescribe this recommended product was solely based on my determination of medical necessity set forth herein. This document may serve as a confirmation of a verbal order and is also recorded in the patient's record.*

Assignment of Benefits: *I request that payment of my insurance benefits be made to CHC Solutions, Inc., or any of its subsidiaries, for any supplies or services they provide me. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home cannot be returned if opened. By signing below, I authorize the distribution of my information to CHC Solutions, Inc., or any of its subsidiaries, which may be needed to determine benefits payable for these services or supplies. I authorize CHC Solutions, Inc., or any of its subsidiaries, to forward my medical records to the medical professionals in my care and/or make copies of said records.*

Patient Signature: _____ Date: _____/_____/_____