IMPACTMEDICAL

Fax: (866)229-0034 Phone: (866)217-0372

Order Date: _____

Name: _____ DOB: _____

Address: _____

Is the patient on Home Health? Yes No Is the patient in a Long Term Care Facility? Yes No

Wound #1 ICD-10: _____ _____ **Location:** _____ **Length** _____ X **Width** _____ X **Depth** _____

Duration: *15 days 30 days* **Drainage Amount:** *None Small/Scant Moderate Large*

Debridement: *Sharp Enzymatic Mechanical Autolytic* **Frequency:** *Daily Every 48 hrs. 3/week Weekly*

Wound #2 ICD-10: _____ _____ **Location:** _____ **Length** _____ X **Width** _____ X **Depth** _____

Duration: *15 days 30 days* **Drainage Amount:** *None Small/Scant Moderate Large*

Debridement: *Sharp Enzymatic Mechanical Autolytic* **Frequency**: *Daily Every 48 hrs. 3/week Weekly*

Wound #3 ICD-10: _____ _____ **Location:** _____ **Length** _____ **X Width** _____ X **Depth** _____

Duration: *15 days 30 days* **Drainage Amount:** *None Small/Scant Moderate Large*

Debridement: *Sharp Enzymatic Mechanical Autolytic* **Frequency:** *Daily Every 48 hrs. 3/week Weekly*

PRIMARY DRESSING Wound

No to Small Drainage

- Hydrogel (Sheet or Gauze) 1 2 3
- Hydrogel Tube (Plain or AG) 1 2 3

Any Drainage

- BioPad 1 2 3
- Powdered Collagen 1 2 3
- Contact Layer (Plain or AG) *4/month* 1 2 3
- Xeroform Gauze 1 2 3
- Vaseline Gauze 1 2 3

Moderate to Heavy

- Calcium Alginate Sheet (Plain or AG) 1 2 3
- Calcium Alginate Rope (Plain or AG) 1 2 3
- Other: _____ 1 2 3
- Other: _____ 1 2 3

SECONDARY DRESSING Wound

Any Drainage

- Gauze Pads 2x2 4x4 1 2 3
- Bordered Gauze 4x4 6x6 1 2 3
- Conforming Gauze 2" 3" 4" 1 2 3
- Bulky Roll Gauze (Plain of AMD) 1 2 3
- Medipore Cloth Tape 1" 2" 4" 1 2 3

Moderate to Heavy

- Bordered Foam *12/month* 1 2 3
- Non-Bordered Foam *12/month* 1 2 3
- RTD Foam *12/month* 1 2 3
- Polymem (Plain or AG) *12/month* 1 2 3
- ABD Pads 1 2 3
- Other: _____ 1 2 3
- Other: _____ 1 2 3

Incidentals: ☐ Saline ☐ Gloves ☐ Cotton tipped applicators ☐ Povidone ☐ Skin Prep ☐ Adhesive Remover

Compression Wraps

- ☐ Circaid Juxta-Lite
- ☐ Juzo Compression Calf Wrap
- ☐ Farrow Wraps

Compression Garments

- ☐ Single Layer Stocking
- ☐ Dual Layer Stocking
- ☐ Other: _____

Compression measurements	Left	Right
Ankle		
Calf		
Knee to heel		

Patient's Approval

Patient's Signature _____ Date_____ Patient's Name: _____

I request that payment of authorized medical benefits be made to Impact Medical Services LLC. for any covered service furnished to me. I am always responsible for the deductible, co-insurance and unassigned uncovered services. I agree to pay Impact Medical Services LLC. any payment made directly to me by insurance for services provided by Impact Medical Services LLC. on an assigned basis. I authorize the release of any medical or other insurance information to process this claim. I also request payment of government benefits either to me or to Impact Medical Medical Services LLC.

Provider's Approval

Provider's Signature: _____ Date: _____

Provider's Name: _____ NPI: _____

I attest by my signature that it is my intention for this prescription to remain valid until, the underlying disease/diagnosis described above is resolved or otherwise directed by the signer.