Eden MEDICAL SUPPLY

Telephone: 800.838.3560
Fax: 866.292.6645
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WOUND CARE DETAILED WRITTEN ORDER

PATIENT INFORMATION

Name: **Date of Birth:**
Phone Number: **Insurance ID:**
Address: **Insurance Name:**
Gender: ☐ M ☐ F

PHYSICIAN INFORMATION

Name: **Phone:**
Address: **Fax:**
NPI:

SUPPLIES TO PRESCRIBE

Please complete steps 1 - 5. Note -- If patient has more than one wound, please complete steps 1-4 for each wound.

STEP 1: Check off the **product(s)** to prescribe for the patients wound.

STEP 2: Circle the corresponding **size** for prescribed item.

STEP 3: Complete **Qty/Change** and **Change Frequency** for each selected product.

PRIMARY DRESSING

PRODUCT	SIZE	QTY / CHANGE	CHANGE FREQ.
☐ Collagen	2x2 4x4		
☐ Collagen with Silver	2x2 4x4		
☐ Calcium Alginate	2x2 4x4 4x8		
☐ Silver Alginate	2x2 4x5		
☐ Hydrogel	3oz 2x2 4x4		
☐ Silver Hydrogel	1.5oz 3oz		
☐ Hydrocolloids Thick/Thin	2x2 4x4 6x6		
☐ Hydrocolloids Bordered	4x4 6x6 6x8		
☐ Gauze	2x2 4x4 4x8		
☐ Antimicrobial (AMD) Gauze	2x2 4x4		
☐ Other	_____		

SECONDARY DRESSING

PRODUCT	SIZE	QTY/ CHANGE	CHANGE FREQ.
☐ Abdominal Pads	5x9 8x7.5 8x10		
☐ Foam	2x2 4x4 4x8		
☐ Bordered Foam	4x4 6x6 6x8		
☐ Composite	4x4 6x6 6x8		
☐ Bordered Gauze	4x4 6x6 6x8		
☐ Kerlix	3" 4"		
☐ Antimicrobial (AMD) Kerlix	4"		
☐ Roll Gauze Conform	2" 3" 4"		
☐ AMD Roll Gauze Conform	2" 3" 4"		
☐ Cloth Tape	1" 2" 3"		
☐ Medipore Tape	1" (2/pk) 2" 3"		

WOUND DIAGNOSIS

STEP 4: Enter the diagnosis code applicable to the patients wou**nd and how long the supplies are needed.**

ICD-10 DIAGNOSIS CODE: _____

Length of Need: _____

CERTIFICATION

I certify that this order is reasonable and medically necessary and not merely a convenience item or it is a mandated benefit. The quantities authorized above are medically necessary based on the wound characteristics documented on this order and in the patient's medical record. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. PLEASE KEEP A COPY OF THIS ORDER FOR YOUR PATIENT'S CHART.

STEP 5: Please sign and date.

Ordering Physician or Licensed Prescriber: _____ **NPI #:** _____

Signature: _____ **Date:** _____

Eden MEDICAL SUPPLY

7300 N Federal Hwy, Ste 102
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MEDICAL RECORD ADDENDUM

Medical Necessity Corroboration for Surgical Supplies

Patient Name: **Doctor Name:**

Date of Birth: **Doctor NPI:**

Surgical supplies were recently ordered for the above patient. Please complete the wound assessment below (Steps 1-4) to confirm medical necessity and keep a copy in your medical records.

1. WOUND IDENTIFICATION

Wound Type *(select one):*

☐ Pressure ulcer ☐ Venous ulcer ☐ Arterial ulcer ☐ Diabetic ulcer

☐ Surgical wound ☐ Traumatic wound ☐ Burn ☐ Skin tear

☐ Other: _____

Location *(anatomical site):* _____

Laterality: ☐ Left ☐ Right ☐ N/A

2. WOUND ASSESSMENT

Measurements *(in cm):*

Length _____ **X** Width _____ **X** Depth _____

Pressure Injury Stage *(if applicable):*

☐ Stage II ☐ Stage III ☐ Stage IV

Wound Thickness *(select one):*

☐ Partial ☐ Full

Drainage Amount *(select one):*

☐ Dry ☐ Minimal ☐ Moderate ☐ Heavy

3. SURGICAL / DEBRIDEMENT HISTORY

Surgically Created Wound? ☐ Yes ☐ No

Debrided Within Last 30 Days? ☐ Yes ☐ No

Date of Surgery *(if applicable)*: _____

Date of Most Recent Debridement *(if applicable)*: _____

I affirm that the patient meets criteria for the product(s) prescribed on the Standard Written Order (SWO). I affirm that the SWO has been completed, signed, & sent to Eden Medical Supply for fulfillment.

4. Signature: _____

Fax Number: 866.203.7535

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