TOTAL WOUND CARE SOLUTIONS
A Division of Tidewater Medical

Phone: (888) 858-9988 Fax: (866) 991-6282

Wound Dressing Order Form

Patient Name: **Phone:**

Facility: **Fax:**

(Please include the ***Patient Information*** Sheet with the order form.)

WOUND ASSESSMENT

WOUND LOCATION ICD-9 or ICD-10	WOUND TYPE	LENGTH	WIDTH	DEPTH	THICKNESS (CIRCLE)	DRAINAGE (CIRCLE)
1					Partial Full	NONE MIN MOD HEAVY
2					Partial Full	NONE MIN MOD HEAVY
3					Partial Full	NONE MIN MOD HEAVY
4					Partial Full	NONE MIN MOD HEAVY

IS WOUND DEBRIDED? YES

IS PATIENT CURRENTLY BEING SEEN BY HOME HEALTH? YES / NO

DURATION OF NEED? 90 DAYS

DRESSING INFORMATION

	Drainage Type	Frequency	1	2	3	4
Collagen		Daily				
Silver Collagen		Daily				
Calcium Alginate	Mod/Heavy	Daily				
Silver Alginate	Mod/Heavy	Daily				
Calcium Alginate Rope	Mod/Heavy	Daily				
Foam	Mod/Heavy	3 x Week				
Bordered Foam	Mod/Heavy	3 x Week				
Silver Foam	Mod/Heavy	3 x Week				
Hydrogel	No/Min	3 oz.				
Adaptic		Daily				
Gauze		Daily				
Kerlix AMD/ Bioguard		Daily				
Conforming Roll Gauze		Daily				
Tubular Dressing		Daily				
Tape		Daily				
ABD	Mod/Heavy	Daily				

OTHER PRODUCTS

COMPRESSION STOCKINGS

(Circle) **Appropriate**

Right Leg **Left Leg**

Patient must have an open venous ulcer to qualify:

Open Venous Statis Ulcer? YES NO

30-40 mmHg	40-50 mmHg

LEG MEASUREMENTS:

	ANKLE	CALF	LENGTH
LEFT			
RIGHT			

COMPRESSION STOCKINGS:

	Carolon Multi-Layer Compression System
	Circaid- Juxta Lite
	Jobst Ulcer Care
	Jobst Ulcer Care w/ Zipper
	Sigvaris 860 Comfort Series
	Other:

ASSIGNMENT OF BENEFITS

I request that all payments from any insurance carrier, including Medicare, Medicaid or private insurance company be made on my behalf to Tidewater Medical Inc (TWM) for any equipment, supplies or services provided to me by TWM Inc. I authorize the release of my medical information to HCFA and/or my insurance carrier and its agencies for the purpose of review of healthcare benefits for the determination of payment. I understand that I am responsible for any remaining balance on my account after my insurance has processed each claim. This authorization will remain in effect until written notification by myself or my legal representative has been received.

Physician Name: _____ **NPI#:** _____

Signature: _____ **Date:** _____

Patient/ Caregiver Signature: _____

Date: _____