Wound Care Quick Start Form/CMN

Fax prescription to: (601) 919-0974

Total Healthcare Solutions
7048 Old Canton Road, Suite 2E Ridgeland, MS 39157 phone: (601) 919-0972

Is this patient currently under home health? Yes No

Patient Name: _____ DOB: _____ Date Ordered: _____

Length of Need: 30 days 60 days 90 days Drainage: Dry Minimal Moderate Heavy

Frequency of Dressing Change: QD BD _____ Surgery/Debrided Date _____/_____/_____

DX Codes: _____ _____ _____ _____

Name of Facility: _____ Contact Person: _____ Phone: _____ Ext: _____

Wound Type	Stage	Length (cm)	Width (cm)	Depth (cm)
1)	_____	_____	X _____	X _____
2)	_____	_____	X _____	X _____
3)	_____	_____	X _____	X _____
4)	_____	_____	X _____	X _____

Notes and\or Additional Supplies needed:

WOUND CARE SUPPLIES *(circle products needed)*						**Wound 1**	**Wound 2**	**Wound 3**	**Wound 4**
ABD Pad	5 x 9	8 x 10							
Adaptic	3 x 3	3 x 8							
Calcium Alginate	2 x 2	4 x 4	4 x 8	Rope					
Composite	2 x 2	4 x 4	4 x 6						
Xeroform	2 x 2	4 x 4	5 x 9						
Gauze / AMD Gauze	2 x 2	4 x 4							
Bordered Gauze	2 x 2	4 x 4	6 x 6						
Amorphous Hydrogel / With Silver			1.5 oz	3 oz					
Hydrogel Saturated Gauze		2 x 2	4 x 4						
Hydrocolloid: Thick / Thin		2 x 2	4 x 4	6 x 6					
Foam / Bordered Foam		2 x 2	4 x 4	6 x 6					
Four Layer Compression System									
Prisma / Promogran	4.34 sq inches								
Coban	2"	3"	4"	6"					
Silver Alginate	2 x 2	4 x 5	Rope						
Unnaboot / With Calamine		3"	4"						
Kerlix Roll Gauze / AMD Roll Gauze		4.5" x 4.1yds							
Roll Gauze Conforming	2"	3"	4"	6"					
Transparent Dressing	2 x 3	4 x 5	6 x 8						
Collagen Dressing	2 x 2	4 x 4	1gm Powder						
Packing Strips: Plain / Iodoform	1/4"	1/2"	1"	2"					
Tape: Paper / Plastic / Cloth	1"	2"							

Physician Name (Print) Physician Signature NPI# Date

I request that payment of my insurance benefits be made to Total Healthcare Solutions 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. I authorize any holder of my medical information to release to Total Healthcare Solutions any information needed to determine benefits payable for these supplies or services. Further, I authorize Total Healthcare Solutions to forward my medical records to the medical professionals in my care and/or make copies of said records.

Patient Signature or Relationship