



P.O. Box 476 Elkin, NC 28621
Phone/Fax: (800) 975-6321

Prescription Form

TG01

Patient's Name: _____ Date: _____

Facility Name: _____ City/State: _____ Phone: _____

Case Manager: _____

In order to process your patient's order, we need the following documentation faxed along with this form:

1. PATIENT FACE SHEET (INSURANCE CARD) 2. ASSESSMENT RECORD 3. ASSIGNMENT OF BENEFITS (BELOW)

Is this patient currently being seen by Home Health?
 Yes No

Is this patient allergic to latex?
 Yes No

OTHER PRODUCTS
(SPECIFY WOUND NUMBER AND FREQUENCY)

DRESSINGS	FREQUENCY	WOUND 1	WOUND 2	WOUND 3	WOUND 4
HYDROCOLLOID					
HYDROGEL					
FOAM DRESSING					
FOAM W/ ADHESIVE					
BULKY GAUZE ROLL					
CONFORMING GAUZE ROLL					
ABD PADS					
STERILE GAUZE 2X2 4X4					
BORDERED GAUZE					
TAPE 1" 2" 3"					

Compression Stocking:

Mediven Plus 30/40 40/50
Mediven Ulcer Kit (2 Layer) 40 mmHg
Juzo

Measurements:

Right Leg Left Leg

ANKLE		
CALF		
CALF LENGTH		

This patient has been shown how to properly use the above prescribed products.

	ICD9 CODES/DESCRIPTION	SIZE	LOCATION	EXUDATE	DURATION
WOUND 1				N L M H	15 30 60
WOUND 2				N L M H	15 30 60
WOUND 3				N L M H	15 30 60
WOUND 4				N L M H	15 30 60

Have the wound(s) been debrided? Yes No

Physician's Name: _____ NPI: _____

Physician's Signature: _____ Date: _____

Assignment of Benefits

I request that payment of my insurance benefits be made to Prism Medical Products, L.L.C. 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 Prism Medical Products, L.L.C. any information needed to determine benefits payable for these supplies or services. Further, I authorize Prism Medical Products, L.L.C. to forward my medical records to the medical professionals in my care and/or make copies of said records.

Patient's Signature: _____ Date: _____