

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Facility Name \_\_\_\_\_

**PLEASE INCLUDE PERSONAL AND INSURANCE INFORMATION WITH ORDER FORM**

**It is imperative to determine if a nurse is coming into the home for any reason.**  
Patient is receiving home health: \_\_\_\_\_ Yes \_\_\_\_\_ No  
**WCR CANNOT BILL WHILE THE PATIENT IS RECEIVING HOME HEALTH SERVICES**

**Carolon Multi-Layer Compression System**  
Patient must have an open venous ulcer to qualify.  
(circle choices below)  
Size: A B C D E F G  
Leg: R L Both  
Color: Beige Black (F and G beige only)  
Class II (30-40 mmHg) Class III (40-50 mmHg)

Ankle Cir	Calf Cir	Length Heel to bend in knee	Size
7" - 8"	10" - 13"	To 15" - short	A
		Over 15" - reg	
8" - 9"	12" - 15"	To 16" - short	B
		Over 16" - reg	
9" - 10"	14" - 17"	To 17" - short	C
		Over 17" - reg	
10" - 11"	16" - 19"	To 18" - short	D
		Over 18" - reg	
11" - 12"	18" - 21"	To 18" - short	E
		Over 18" - reg	
12" - 13"	20" - 23"	To 18" - short	F
		Over 18" - reg	
13" - 14"	22" - 26"	To 18" - short	G
		Over 18" - reg	

If both legs are involved, please measure separately.  
Circle two sizes if needed.

**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 Wound Care Resources, Inc. (WCR) for any equipment, supplies or devices provided to me by WCR. 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. This authorization will remain in effect until written notification by myself or my legal representative has been received. I am responsible for any balance due not covered by my insurance.

**Patient Rights**

I have been informed of my Patient's Rights to Privacy given me by my Physician's Office:

\_\_\_\_\_  
Patient/Caregiver Signature Date

\_\_\_\_\_  
Physician Name NPI#

\_\_\_\_\_  
Physician Signature Date

\_\_\_\_\_  
Physician Phone

WOUND INFORMATION (circle choices & fill in spaces)												
Wound Stage	Wound 1				Wound 2				Wound 3			
	II	III	IV	P F	II	III	IV	P F	II	III	IV	P F
ICD9 code												
Size L x W x D												
Location												
Drainage	min mod heavy				min mod heavy				min mod heavy			
Is wound debrided?	yes no				yes no				yes no			
Duration of need	15 30 60 90				15 30 60 90				15 30 60 90			
Frequency	qd qod wkly				qd qod wkly				qd qod wkly			

CUSTOMIZED DRESSING ORDERS						
PRODUCT	STYLE (circle choice below)	DRAINAGE	UNITS/MO. (per wound)	Wound 1 2 3		
calcium alginate	2x2, 4x5, ¾ x 12	mod-heavy	30			
Silverlon alginate	2x2, 4x5, ¾ x 12	mod-heavy	30			
Medihoney alginate	2x2, 4x5, ¾ x 12	mod-heavy	30			
hydrogel sheet	2x3, 4x4, 4x8	no-min	30			
Anasept Gel	3 oz tube	no-min	3 oz.			
Silver-Sept Gel	1.5 oz., 3 oz. tube	no-min	3 oz.			
Tegaderm Matrix	4x4	no-min	30			
Promogran	4.34x4.34	any	12-30			
Prisma	4.34x4.34	any	12-30			
non-adherent dressing	3x3, 3x8	any	30			
transparent film	2x3, 4.25 x4.25	any	12			
ABD pad	5x9, 8x10	mod-heavy	30			
foam	4x4, 4x8, 6x6	mod-heavy	12			
bordered foam	1.6x2, 3x3, 4x4, 6x6,	mod-heavy	12			
Kerlix AMD	roll	any	up to 30			
gauze roll	roll	any	up to 30			
conforming gauze	stretch roll	any	up to 30			
bordered gauze	2x2, 4x4, 6x6	any	up to 30			
gauze sponge	2x2, 4x4	any	as needed			
tape 2" 3" 4"	paper / transp / silk	any	2rolls / wnd			
Mefix 2" 4" 6"	cloth	any	1 roll / wnd			

OTHER PRODUCTS OR SPECIFIC BRANDS (list here)				1	2	3
TheraGauze	2x2, 4.12x4.12	no-min	30			