520 Boston Post Rd, Old Saybrook, CT 06475
860-388-1437 FAX: 860-388-0368
www.northeastmedicalproducts.com
An Innova Medical Group Company

INNOVA MEDICAL PRODUCTS

WOUND CARE PRESCRIPTION FORM

Patient Name _____ Phone _____

Address _____

Email _____

Physician _____ Date of Evaluation _____

Alternate Contact Name _____ Relationship _____ Phone _____

Description of Wound

	Wound # _____				Wound # _____				Wound # _____				Wound # _____			
Type of Wound																
Location																
Size (l x w) (cm)																
Depth (cm)																
Stage (I-IV)																
Amount of Drainage																
Date/Type Debridement*																
Dressings Used	(a)	(b)	(c)	(d)	(a)	(b)	(c)	(d)	(a)	(b)	(c)	(d)	(a)	(b)	(c)	(d)

(a) = Dressing reference # from table below (All Primary and Secondary dressings used for each wound)
(b) = Quantity used per dressing change
(c) = Frequency of dressing change
(d) = How many days do you anticipate using these dressings? **

Dressing Ref #	Dressing Brand Name	Size	HCPCS#

Source of Information used to complete this form:

☐ Nursing Home Records ☐ Home Care Records ☐ Physician Office Records

☐ Other (specify) _____

I certify that I obtained the information in this form from the stated source and that the original records are available for review:

Provider Name _____ Phone Number _____

Provider Signature _____ Date _____

** Debridement initiates uses of the Surgical Dressing policy ONLY and is not required with every dressing change.*
*** Medicare requires you to estimate an anticipated length of time of use (no. of days) for each dressing.*
This should coincide with scheduled wound assessments so that dressing appropriateness is assessed at the same time.