Advanced Wound Care Order Form

Mölnlycke®

Fax this form and patient records to **207-784-7992**
Also available at **MyBedard.com/referral-forms**

bedard MEDICAL SUPPLIES
Phone: 207-784-3700

1. Patient Information

Patient Name:______________________ DOB:______________ Phone #:______________________

Is patient current in a facility? ☐ Y ☐ N If yes, Facility Name:______________________ Facility Phone #:______________________

Is patient receiving home health or outside assistance in the home? ☐ Y ☐ N If yes, Agency Name:______________________

Has patient received any of the below supplies within the last 30 days? ☐ Y ☐ N

2. Wound Assessment & Documentation

	Wound #_______	Wound #_______	Wound #_______	Wound #_______
ICD-10 Code				
Reason for Dressing	☐ Surgical Wound ☐ Debridement - Surgical ☐ Debridement - Mechanical ☐ Debridement - Autolytic ☐ Debridement - Chemical ☐ Other:__________	☐ Surgical Wound ☐ Debridement - Surgical ☐ Debridement - Mechanical ☐ Debridement - Autolytic ☐ Debridement - Chemical ☐ Other:__________	☐ Surgical Wound ☐ Debridement - Surgical ☐ Debridement - Mechanical ☐ Debridement - Autolytic ☐ Debridement - Chemical ☐ Other:__________	☐ Surgical Wound ☐ Debridement - Surgical ☐ Debridement - Mechanical ☐ Debridement - Autolytic ☐ Debridement - Chemical ☐ Other:__________
Wound Type				
Stage	☐ I ☐ II ☐ III ☐ IV ☐ Unstageable ☐ Deep Tissue Injury	☐ I ☐ II ☐ III ☐ IV ☐ Unstageable ☐ Deep Tissue Injury	☐ I ☐ II ☐ III ☐ IV ☐ Unstageable ☐ Deep Tissue Injury	☐ I ☐ II ☐ III ☐ IV ☐ Unstageable ☐ Deep Tissue Injury
Wound Size (LxWxD)	cm	cm	cm	cm
Thickness	☐ Partial ☐ Full	☐ Partial ☐ Full	☐ Partial ☐ Full	☐ Partial ☐ Full
Wound Location	☐ LT ☐ RT	☐ LT ☐ RT	☐ LT ☐ RT	☐ LT ☐ RT
Drainage	☐ None ☐ Light ☐ Mod ☐ Hvy	☐ None ☐ Light ☐ Mod ☐ Hvy	☐ None ☐ Light ☐ Mod ☐ Hvy	☐ None ☐ Light ☐ Mod ☐ Hvy

3. Physician's Order & Authorization

BY SIGNING, I AUTHORIZE the use of this document as an order, and I certify that the below prescribed supplies are medically necessary and reasonable.

Physician Name:______________________ NPI #:______________________ Phone #:______________________

Adddress:______________________ Fax #:______________________

Physician Signature:______________________ Date:______________________

Product	Quantity	# of Refills	Primary / Secondary / Other	Wound #_____ Freq of Change	Wound #_____ Freq of Change	Wound #_____ Freq of Change	Wound #_____ Freq of Change
Alldress *(Composite)*			☐ Primary ☐ Secondary ☐ Other				
Exufiber *(Gelling Fiber)*			☐ Primary ☐ Secondary ☐ Other				
Exufiber Ag+ *(AMD Gelling Fiber)*			☐ Primary ☐ Secondary ☐ Other				
Melgisorb Plus *(Calcium Alginate)*			☐ Primary ☐ Secondary ☐ Other				
Melgisorb Ag *(AMD Calcium Alginate)*			☐ Primary ☐ Secondary ☐ Other				
Mepilex Border *(Bordered Foam)*			☐ Primary ☐ Secondary ☐ Other				
Mepilex Border Ag *(AMD Bordered Foam)*			☐ Primary ☐ Secondary ☐ Other				
Mepilex Border Flex *(Bordered Foam)*			☐ Primary ☐ Secondary ☐ Other				
Mepilex Border Heel *(Bordered Foam)*			☐ Primary ☐ Secondary ☐ Other				
Mepilex Border Sacrum *(Bordered Foam)*			☐ Primary ☐ Secondary ☐ Other				
Mepilex Border Sacrum Ag *(AMD Bordered Foam)*			☐ Primary ☐ Secondary ☐ Other				
Mepitac *(Fixation Tape)*			☐ Primary ☐ Secondary ☐ Other				
Mepitel *(Contact Layer)*			☐ Primary ☐ Secondary ☐ Other				
Mepitel Ag *(AMD Contact Layer)*			☐ Primary ☐ Secondary ☐ Other				
Mepore *(Non-Adherent)*			☐ Primary ☐ Secondary ☐ Other				
Mepore Film *(Transparent Film)*			☐ Primary ☐ Secondary ☐ Other				
Mesalt *(Sodium Chloride Wound Cleansing)*			☐ Primary ☐ Secondary ☐ Other				
Normlgel Ag *(AMD Wound Gel)*			☐ Primary ☐ Secondary ☐ Other				
OTHER:			☐ Primary ☐ Secondary ☐ Other				
OTHER:			☐ Primary ☐ Secondary ☐ Other				