

Clinic Name	
Clinic Phone #	Clinic Fax #



FAX # 888-655-6244

Order	Patient
Date:	Name

Fax or email with Patient Information Sheet
orders@halodme.com Phone # 888-711-2014

Have patient's wound/s ever been debrided? (Debridement is required by Medicare)	YES / NO
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REP ID #	Web
Is patient currently seen by Home Health?	YES / NO

WOUND INFORMATION	ICD-10 / Description	Wound Thickness	LOCATION	Wound Size (cm) (L x W x D)	Drainage (Exudate)
	Wound 1:	Partial or Full			N L M H
	Wound 2:	Partial or Full			N L M H
	Wound 3:	Partial or Full			N L M H
	Wound 4:	Partial or Full			N L M H

DRESSING SUPPLIES	Dressings Requested <i>(Please Circle Size Requested)</i>	Drainage Required	Max Units Per Month unless Spec.	Frequency of Change Daily unless Spec.	Wound Number (X for supplies)			
					Wound #1	Wound #2	Wound #3	Wound #4
	Collagen w/ Silver: (2x2) (4x4) (8x8)	Low/Mod	30					
	Collagen: (2x2) (4x4) (8x8)	Low/Mod	30					
	Collagen Powder (1 gram)	Low/Mod	30					
	Calcium Alginate w/ Silver: (2x2) (4x4) (6x6) (4x8) Other: _____	Mod/Heavy	30					
	Calcium Alginate: (2x2) (4x4) (6x6) (4x8) Other: _____	Mod/Heavy	30					
	Gelling Fiber w/ Silver: (2x2) (4x4) (6x6) (4x8) Other: _____	Mod/Heavy	30					
	Gelling Fiber: (2x2) (4x4) (6x6) (4x8) Other: _____	Mod/Heavy	30					
	Hydrogel: (3oz) (2x2) (4x5)	None/Low	3 OZ / 30					
	Foam Dressing: (2x2) (3x3) (4x4) (6x6) (8x8) (Sacral) Other: _____	Mod/Heavy	12					
	Foam w/ Border: (2x2) (3x3) (4x4) (6x6) (8x8) (Sacral) Other: _____	Mod/Heavy	12					
	ABD Pad: (5x9) (8x10) (12x16)	Mod/Heavy	30					
	Antimicrobial Roll Gauze: (4" unless Specified)	Any	30					
	Gauze Pad: (2x2) (4x4)	Any	100					
	Antimicrobial Gauze 4x4	Any	30					
	Tape (2" Paper unless specified.):	Any	2 Rolls					
	Coban (2" unless specified.):	Any	30					

COMPRESSION	COMPRESSION MEASUREMENTS				COMPRESSION LEVEL	COMPRESSION WRAP	COMPRESSION STOCKINGS		
	LEG (CM's)	ANKLE	CALF	LENGTH	<input type="checkbox"/> 30-40 mmHg		<input type="checkbox"/> Juxtalite	<input type="checkbox"/> Mediven Dual Layer	
	Right				<input type="checkbox"/> 40-50 mmHg		<input type="checkbox"/> Juzo	<input type="checkbox"/> Juzo (Ulcer, Soft, Dual Stretch, Dynamic)	
	Left				<input type="checkbox"/>		<input type="checkbox"/> Farrow Basic	<input type="checkbox"/> UlcerCare	<input type="checkbox"/> Relief
	Is there an 'Active Venous Leg Ulcer'?				YES / NO	<input type="checkbox"/> ReadyWrap	<input type="checkbox"/>		

* I request that payment of my insurance benefits for any supplies be made to BioResolutions LLC. 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 BioResolutions LLC any information needed to determine benefits payable for these supplies or services. I acknowledge receipt and understanding of the patient rights that BioResolutions LLC provides to all patients.

Patient Signature:	Date:
I attest by my signature that it is my intention for the prescription to remain valid until the diagnosis described is resolved or otherwise directed by the signer. The requested supplies are medically necessary and the wound(s) has/have been debrided and/or surgically created or modified. I have instructed the patient on how to use the supplies being requested.	Duration of Treatment will be 90 Days unless specified:
Provider Signature:	Signed Date: