Clinic Name			
Clinic Phone #		Clinic Fax #	

FAX # 888-841-7082

Fax or email with Patient Information Sheet

orders@halodme.com Phone # 888-711-2014

Order Date: _____	Patient Name _____

REP ID # Web

Have patient's wound/s ever been debrided? (Debridement is required by Medicare)	YES / NO

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 *(Please Circle Size Requested)*	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
LEG (CM's)	ANKLE	CALF	LENGTH	☐ 30-40 mmHg
Right				☐ 40-50 mmHg
Left				☐
Is there an 'Active Venous Leg Ulcer'?	YES / NO			

COMPRESSION WRAP	COMPRESSION STOCKINGS	
☐ Juxtalite	☐ Mediven Dual Layer	
☐ Juzo	☐ Juzo (Ulcer , Soft , Dual Stretch , Dynamic)	
☐ Farrow Basic	☐ UlcerCare	☐ Relief
☐ ReadyWrap	☐	

SIGNATURE

* 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: _____

X **Provider Signature:** _____ **Rx Date:** _____