

Patient
 Re-order

 Face Sheet Attached

Order Date _____ of _____

Name (L) _____ (F) _____

Ordered by _____

Address _____ Apt # _____

 Male Female D.O.B. _____

City _____ St _____ Zip _____

Cell # (_____) _____

Primary Ins _____ Policy # _____ GP # _____

Other Ins _____ Policy # _____ SSN _____

Ins Tel # (_____) _____

Pt. email _____

Referral Phone _____

Dr. / Prescriber
 _____ _____ _____

By signing this form, I confirm the physician signature corresponds to the name and NPI detailed above and that I am prescribing the items and quantities listed below.


Signature X _____

Date _____

Duration of Need - 3 months unless indicated otherwise
Other _____ (mths)

Wound Location

	Days Supply		Diagnosis - ICD.10	Drainage				Dimensions (cm's)			Thickness	
	15	30		Dry	Lt	Mod	Hvy	Length	Width	Depth	Part	Full
1 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
2 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
3 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
4 _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

Starter Kits	Wnd#	1	2	3	4
		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Starter Kits contain (3) primary dressings, (3) sterile conforming bandages 3" and (1) roll paper tape 2".

Amount per dressing change equals one unless stated otherwise.

Medical Record - please be sure the chart notes contain medical justification to support this order and specify the type of debridement on non-surgical wounds (sharp, autolytic, enzymatic, mechanical, etc.)

Stalled	Bioburden	Thickness		Drainage		Wound Size (S.I.)	Primary Dressing	Secondary Dressing	Change Freq.	Guideline (up-to)	(If blank use Guideline)	Wound #			
		Partial	Full	Mod	Heavy							1	2	3	4
↓	↕	↓	↓	↓	↓	4	Collagen	2 x 2	Conforming Bandage St. 3" plus 2' paper tape	Daily		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						16		<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
						49		<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
↓	↕	↓	↓	↓	↓	4	Collagen Ag	2 x 2				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						16		<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
						49		<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
↓	↕	↓	↓	↓	↓	4	Collagen	2 x 2	Superabsorber with Border	3.5 x 4		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						16		<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
						49		<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
↓	↕	↓	↓	↓	↓	4	Collagen Ag	2 x 2		3.5 x 4		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						16		<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
						49		<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
↓	↕	↓	↓	↓	↓	4	Alginate	2 x 2	Conforming Bandage St. 3" plus 2' paper tape			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						20		<input type="checkbox"/>				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
						4	Alginate Ag	2 x 2				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
↓	↕	↓	↓	↓	↓	20		4 x 5				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						16	Superabsorber	4 x 4				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						40		6 x 10				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
↓	↕	↓	↓	↓	↓	9	Superabsorber	3 x 3	Foam Silicone plus 2' paper tape	4 x 5	Q3D	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						16		4 x 4				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						2	Foam Silicone	2 x 2				Conforming Bandage St. 3" plus 2' paper tape			<input type="checkbox"/>
12		4 x 5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
36		8 x 8	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									
↓	↕	↓	↓	↓	↓	2	Foam Silicone Ag	2 x 2				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						12		4 x 5				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
						36		8 x 8				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Dispense as Written

Compression - Only covered with open venous stasis ulcer

DX1 _____ DX2 _____

mmHg	Ankle	Mid-Calf	Heel/Back Knee	Style	Brand
Right <input type="checkbox"/> 30-40	_____ cm	_____ cm	_____ cm	<input type="checkbox"/> Calf <input type="checkbox"/> Open <input type="checkbox"/> Above	<input type="checkbox"/> CompreFlex Lite* <input type="checkbox"/> ReadyWrap <input type="checkbox"/> Juzo
Left <input type="checkbox"/> 30-40	_____ cm	_____ cm	_____ cm	<input type="checkbox"/> Ankle <input type="checkbox"/> Closed <input type="checkbox"/> Below	<input type="checkbox"/> JuxtaLite* <input type="checkbox"/> Jobst <input type="checkbox"/> Medi Dual Layer
					<input type="checkbox"/> Carolon <input type="checkbox"/> Sigvaris <input type="checkbox"/> Farrow*

* One per six (6) months per leg.

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