Community Medical Supply

Rep: Casey Tebbs **Phone**: 888.688.6149 **Fax**: 888.412.7605

Patient Intake Information

Patient Name		MRN:	
Patient Phone:		Is patient on HH?	☐ Yes ☐ No
Clinic:		Patient knows how to use product?	☐ Yes ☐ No
Patient Email:		Fax:	Phone:

Wound Information

	Wound 1	Wound 2	Wound 3	Wound 4
ICD10/Diagnosis:				
Exudate:	☐ None ☐ Low ☐ Mod ☐ Heavy	☐ None ☐ Low ☐ Mod ☐ Heavy	☐ None ☐ Low ☐ Mod ☐ Heavy	☐ None ☐ Low ☐ Mod ☐ Heavy
Location:				
Dimensions:	x x	x x	x x	x x
Qualifying Wound:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Change Frequency:	☐ Q2 ☐ Q3 ☐ QD ☐ Other:	☐ Q2 ☐ Q3 ☐ QD ☐ Other:	☐ Q2 ☐ Q3 ☐ QD ☐ Other:	☐ Q2 ☐ Q3 ☐ QD ☐ Other:

Wound Care Products

Dispensing Frequency - Every ☐ **15** ☐ **30 (days)** **Duration -** ☐ **90 (days)** **Other:**

	Wound 1	Wound 2	Wound 3	Wound 4
Alginate ☐ AG				
Border Foam ☐ AG				
Non Border Foam ☐ AG				
Collagen ☐ AG				
Hydrogel				
Border Gauze				
Iodosorb ☐ Medihoney ☐				
ABD ☐ Exudry ☐				
AMD Roll Gauze				
Kerlix ☐ Conform ☐				
Retainer/Netting				
Tape Size:				
Other:				
Other:				
Other:				
Other:				
Additional Items	☐ Gloves ☐ Skin Prep ☐ Saline ☐ Cotton Tip Applicator ☐ Barrier Wipes ☐ Adhesive Remover			
Notes				

Measurements		Compression		
Rt Ankle	Lt Ankle	Compression Ratio	Compression Stockings	Compression Wraps
Rt Calf	Lt Calf	☐ 30-40 mmHg ☐ 40-50 mmHg	☐ Juzo Ulcer Pro ☐ Juzo Dynamic	☐ Juzo ☐ JuxtaLite
Rt Length	Lf Length	Other:	Other:	Other:

DRESSING SIZE: PURSUANT TO THE LCD "DRESSING SIZE MUST BE BASED ON AND APPROPRIATE TO THE SIZE OF THE WOUND." PROVIDER'S SIGNATURE BELOW INDICATES SUPPLIER SHOULD USE THE PROVIDED WOUND SIZE(S) TO DETERMINE APPROPRIATE DRESSING SIZE. QUALIFYING WOUNDS ARE EITHER SURGICAL IN NATURE OR HAVE BEEN DEBRIDED. PATIENTS MEDICAL RECORD MUST SUPPORT ONE OR BOTH IN ORDER FOR INSURANCE TO COVER CLAIM.
REFILLS: PROVIDER'S SIGNATURE INDICATES THAT NUMBER OF REFILLS SHOULD BE EQUAL TO; DURATION OF NEED DIVIDED BY DISPENSING FREQUENCY.
QUANTITY: PROVIDER'S SIGNATURE INDICATES THAT QUANTITY OF DRESSINGS DISPENSED PER ORDER/REFILL SHOULD BE EQUAL TO; FREQUENCY OF CHANGE TIMES DISPENSING FREQUENCY. ADDITIONALLY THE PATIENT IS COMPETENT, HAS BEEN INSTRUCTED ON PROPER USE AND SHOULD NOT USE MORE THAN ONE DRESSING PER DAY, PER EACH PRIMARY AND/OR SECONDARY DRESSING(S) ORDERED.

Provider Information			Coordination of Care
Provider Name		Signature: Date:	I attest that I am a provider/clinician providing necessary care to the associated patient who requires coordination of care and Community Medical has the authority to coordinate care on behalf of my patient. The patient has chosen Community Medical to assist in providing the requested care either: providing product, verifying insurance benefits, billing for service or coordinating car for the patient should direct service not be an option.
☐	NPI:	Verbal Order: ☐ Yes ☐ No (If, yes please indicate referring physician and assisting case manager)	
☐	☐		
☐	☐	Name:	Name of Provider/Clinician:
☐	☐	Supplier Signature: Date:	Signature Date: