ACENTUS

Preston
PH: 888-61-WOUND (96863)
FAX: 866-599-6972
prestonwoundcare.com

PATIENT NAME_____ D.O.B._____
IS THE PATIENT SEEN BY HOME HEALTH? ☐ YES ☐ NO KNOWN LATEX ALLERGY? ☐ YES ☐ NO

REFERRAL INFORMATION

FACILITY_____ CONTACT_____

PHONE_____ FAX_____ **ATTACH WOUND ASSESSMENT AND TREATMENT NOTES**

REQUIRED INFORMATION	WOUND 1	WOUND 2	WOUND 3
ICD-10 CODE			
LOCATION	☐ LT ☐ RT _____	☐ LT ☐ RT _____	☐ LT ☐ RT _____
LENGTH X WIDTH X DEPTH	X X	X X	X X
THICKNESS	☐FULL ☐ PARTIAL	☐ FULL ☐ PARTIAL	☐ FULL☐ PARTIAL
DRAINAGE AMOUNT	☐ DRY☐ MIN ☐ MOD☐ HVY	☐DRY☐ MIN ☐ MOD☐ HVY	☐ DRY☐ MIN ☐ MOD☐ HVY
FREQUENCY OF CHANGE			
DEBRIDED METHOD USED WITHIN LIFE OF THE WOUND?	☐ SURGICAL ☐ MECHANICAL ☐ CHEMICAL ☐ AUTOLYTIC	☐ SURGICAL ☐ MECHANICAL ☐ CHEMICAL ☐ AUTOLYTIC	☐ SURGICAL ☐ MECHANICAL ☐ CHEMICAL ☐ AUTOLYTIC
SURGICAL WOUND?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

ORDER WILL BE FILLED IN 30 DAY INCREMENTS
IF NOT OTHERWISE INDICATED

PRIMARY	REQUIRED DRAINAGE	SIZE (PLEASE CIRCLE)	DISPENSE AMT	WOUND 1	2	3
COLLAGEN ☐ AG	LIGHT-MOD	2X2 4X4	15 30			
CALCIUM ALG ☐ AG	MOD-HEAVY	2X2 4X4 4X5 4X8 ROPE	15 30			
HYDROCOLLID	LIGHT-MOD	2X2 4X4 6X6	6 12			
HYDROGEL	NONE-LOW	30Z	3OZ			
SECONDARY						
FOAM ☐ AG	MOD-HEAVY	2X2 4X4 4X8	6 12			
FOAM ADH BDR ☐ AG	MOD-HEAVY	3X3 4X4 4X8 6X6	6 12			
FOAM SILICONE BDR ☐ AG	MOD-HEAVY	3X3 4X4 4X8 6X6	6 12			
HYDROGEL GAUZE ☐ AG	NONE-LOW	2X2 4X4	15 30			
ABD PADS	MOD-HEAVY	5X9 8X10	15 30			
STERILE GAUZE	ANY	2X2 4X4	45 90			
SECURING GAUZE						
CONFORMING GAUZE	ANY	1" 2" 3" 4"	15 30			
TAPE	ANY	1" 2" 4"				
KERLIX	ANY	4"	15 30			

NOTES: ☐ GLOVES ☐ SALINE

SHIPPING ORDERS ON TIME CAN BE AS EASY AS 1-2-3

1. CONFIRM THE ORDER MATCHES ASSESSMENT AND TREATMENT PLAN
2. CONFIRM THE WOUND DRAINAGE MATCHES THE PRODUCT ORDERED
3. CONFIRM SUPPLIES ARE ONLY FOR A DOCUMENTED DEBRIDED OR SURGICAL WOUND
   - **SURGICAL** (SHARP INSTRUMENT OR LASER)
   - **MECHANICAL** (IRRIGATION OR WET TO DRY DRESSING)
   - **CHEMICAL** (TOPICAL APPLICATION OF ENZYMES)
   - **AUTOLYTIC** (APPLICATION OF OCCLUSIVE DRESSING TO OPEN WOUND)

ORDERING PHYSICIAN (PLEASE PRINT):_____

SIGNATURE:_____ DATE:_____

NPI:_____

LENGTH OF NEED: 90 DAYS UNLESS OTHERWISE INDICATED HERE_____

VERBAL ORDER: ☐ YES ☐ NO DATE:_____

CLINICIAN/CASE MANAGER NAME:_____(PRINT NAME)

I Certify that I am the Physician identified on this form. I have reviewed the Physician's Written order. I certify that the medical necessity information is true accurate and complete to the best of my knowledge. I certify that the patient/caregiver is capable and has successfully completed training or will be trained on the proper use of the products prescribed on this written order. The patients record contains supporting documentation that substantiates the utilization and medical necessity of the items listed and supporting documentation will be provided to Acentus/Preston Wound Care upon request. 2.2

COMPRESSION

30-40 mmHg ☐LT ☐RT
40-50 mmHg ☐LT ☐RT
OTHER:_____ ☐LT ☐RT

LEG MEASURMENTS
☐CM ☐IN

CALF LT:_____RT:_____

ANKLE LT:_____RT:_____

LENGTH LT:_____RT:_____

PRODUCTS

COMPRESSION STOCKINGS

SINGLE LAYER ☐LT ☐RT

DOUBLE LAYER ☐LT ☐RT

OTHER_____ ☐ LT ☐RT

COMPRESSION WRAPS

JUXTA LITE ☐LT ☐RT

FARROW WRAP ☐LT ☐RT

COMPREFLEX LITE ☐LT ☐RT