Detailed Written Order
MedQuest USA Universal Drainage Kits

Phone: 630.587.0019

Section A: (Required)

Patient Name:_____ D.O.B.:_____ Sex: ❒ M ❒ F
Patient Phone:_____
Patient Address:_____ City:_____ State:_____ ZIP:_____

Physician Name:_____
Physician Phone:_____
Physician Address:_____ City:_____ State:_____ ZIP:_____
Place of Service: Home

Section B: (Required)

Primary Diagnosis (Location of Fluid Accumulation)

Diagnosis (ICD-10) Check Patient Diagnosis:

❒ J91.8 Unspecified Pleural Effusion ❒ J91.0 Malignant Pleural Effusion other: ☐

❒ R18.0 Malignant Ascites ❒ R18.8 Other Ascites other: ☐

Secondary Diagnosis (Condition Causing Drainage Treatment)

For Example: Diagnosis (ICD-10) C34.90 Lung Cancer, C50.919 Breast Cancer, C56.9 Ovarian Cancer or I50.xx Heart Failure

☐ ☐ ☐

Duration of Need (Months): ☐ **1 – 99 (99 = Lifetime)** ☐ **Start Date**

Check the appropriate box that describes your catheter placement.

❒ Yes ❒ No ❒ Does not apply The catheter was placed for refractive pleural effusion and requires drainage. Placement date: _____

❒ Yes ❒ No ❒ Does not apply The catheter was placed for recurrent ascites and requires drainage. Discharge date: _____

Please indicate the prescribed frequency of use and quantity to be dispensed.

Single Drain

❒ Once per day (90 Drainage Kits in 90 days)
❒ Every other day (45 Drainage Kits in 90 days)
❒ Other (_____ Drainage Kits in 90 days)

Bilateral Drain

❒ Once per day (180 Drainage Kits in 90 days)
❒ Every other day (90 Drainage Kits in 90 days)
❒ Other (_____ Drainage Kits in 90 days)

Note: Each case contains 10 Medquest USA Universal Drainage Kits. Each Universal Drainage Kit contains: vacuum bottle with drainage line, foam pad with cut for catheter, transparent dressing, alcohol wipes (qty. 8), 4″ x 4″ gauze pads (qty. 12), surgical drape, 2 pair Chemo Rated Nitrile Gloves, clamp, vented Luer Cap, no sting barrier film, 1 safety adapter, sterile cap.

Section C: Physician Attestation (Required)

I certify that I am the physician identified on this form. I have reviewed all sections of the Detailed Written Order. Any statement on my letterhead attached hereto, has been reviewed and signed by me. 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 patient's record contains supporting documentation that substantiates the utilization and medical necessity of the products listed and Physician notes and other supporting documentation will be provided upon request. I understand any falsification, omission, or concealment of material fact on this form may subject me to civil or criminal liability. A copy of this order will be retained as part of the patient's medical records.

Please Sign Here Prescriber's Signature_____

Signature Stamps and Date Stamps Are Not Acceptable

Prescriber's Name (printed):_____ **Date**_____/_____/_____ **NPI #:**_____

Fax completed forms to 630.524.9088

Note that incomplete or incorrect forms may experience a delay in processing. Medquest or authorized representative (Ashland Health)

Patient Insurance Information
MedQuest USA Universal Drainage Kits

Phone: 630.587.0019

Patient Information: Complete the following section or attach the patient's face sheet.

Patient Name: Last _____ First _____ MI _____
Patient Phone:_____
Alternative Contact Name: _____ Phone: _____
Patient Address:_____ City:_____ State:_____ ZIP:_____

Insurance Information:

Primary Insurance:_____ Phone:_____
Policyholder:_____ ID #:_____
Employer or Group Name:_____ Group #:_____

Secondary Insurance:_____ Phone:_____
Policyholder:_____ ID #:_____ Group #:_____

Hospital Information:

Hospital:_____
Contact at Physician's Office:_____Phone:_____

Name of Referring Physician:_____ Phone:_____

Patient Care: Complete this section. If applicable.

Patient is being discharged to:

❒ Home with no nurse in home
❒ Nurse in home (HHA/VNA)
❒ Hospice
❒ Skilled Nursing Facility (SNF)

Vacuum Bottle Size:

❒ 1000 ml
❒ 600 ml

Number of bottles discharged with: _____
Care Start Date:_____ Name of Provider:_____
Provider Contact:_____ Phone:_____

******Please fax completed forms to: 630.524.9088******

❒ I would like confirmation the prescription was received. Name:_____
Contact me via ❒ Phone: _____ or ❒ E-Mail: _____

Preserve original order or mail to:

Ashland Health
12 North Catherine Ave.
LaGrange, IL 60525

Notes: _____

Ashland Health must make contact with the patient/caregiver prior to the shipment of any supplies – supplies do not ship automatically.
Depending on the patient's insurance additional documentation may be required.

This prescription or the information contained herein may be shared with or reported to MedQuest USA, the product manufacturer, for quality purposes to ensure that the necessary resources are available to service patients that require the products referenced in this prescription. Such information is furnished in compliance with HIPAA to allow for the best treatment of the patient. Nonetheless, if you or your patient do not wish for this prescription or information to be shared with MedQuest USA, please call 630-587-0019 and a Product Specialist will assist with this request and ensure that the information is not shared.