PLEASE FILL OUT THE ENTIRE FORM AND INCLUDE THE PATIENT'S DEMOGRAPHIC TO **AVOID DELAYS.**

GALAXY MEDICAL SUPPLY

PHONE: (718) 708-7258
FAX: (718) 708-7259
WWW.GALAXYMEDSUPPLY.COM

(SECTION 1) GENERAL INTAKE INFORMATION

PATIENT NAME: _____ ***ORDER START DATE:*** ___/___/____

PATIENT PHONE: (_____)_____ PATIENT DOB: _____/_____/_____

REFERRAL FACILITY: _____ CITY: _____ STATE: _____

REFERRAL PHONE: (_____)_____ FAX: (_____)_____

(SECTION 2) WOUND ASSESSMENT

	WOUND 1	WOUND 2	WOUND 3
DESCRIPTION/ICD-10			
WOUND EXUDATE	☐**NONE** ☐**LOW** ☐**MOD** ☐**HVY**	☐**NONE** ☐**LOW** ☐**MOD** ☐**HVY**	☐**NONE** ☐**LOW** ☐**MOD** ☐**HVY**
WOUND LOCATION	_____ ☐**LT** ☐**RT**	_____ ☐**LT** ☐**RT**	_____ ☐**LT** ☐**RT**
WOUND SIZE (LxWxD)	____x____x____(cm)	____x____x____(cm)	____x____x____(cm)
HAS THE WOUND BEEN DEBRIDED?	☐YES, DATE __/__/__ ☐NO	☐YES, DATE __/__/__ ☐NO	☐YES, DATE __/__/__ ☐NO
WOUND THICKNESS	☐FULL ☐PARTIAL	☐FULL ☐PARTIAL	☐FULL ☐PARTIAL
DURATION OF NEED	☐**90 DAYS** ☐_____ **DAYS** *(FREQUENCY OF CHANGE AND DURATION OF NEED WILL BE USED TO ASSESS QUANTITY TO BE DISPENSED)*		

(SECTION 3) WOUND CARE PRODUCTS

PRODUCTS	**WOUND 1**	**WOUND 2**	**WOUND 3**
items designated by *asterisk require FULL thickness for insurance coverage.	***FREQUENCY OF CHANGE***	***FREQUENCY OF CHANGE***	***FREQUENCY OF CHANGE***
***CALCIUM ALGINATE DRESSING**			
***SUPER ABSORBER (FIBER GEL DRESSING)**			
***COLLAGEN DRESSING**			
***FOAM DRESSING**			
***BORDERED FOAM**			
***SILICONE BORDERED FOAM**			
***HYDROGEL FILLER**			
***HYDROGEL DRESSING**			
***ABD PAD**			
HYDROCOLLOID DRESSING			
CONTACT LAYER			
CONFORMING ROLL GAUZE			
STERILE "BULKY" ROLL GAUZE			
GAUZE			
TAPE			
OTHER:			

GRADIENT COMPRESSION

PRODUCTS

MEDI PLUS ☐ LT ☐ RT

MEDI DUAL LAYER ☐ LT ☐ RT

JUXTA LITE HD ☐ LT ☐ RT

OTHER: ☐ LT ☐ RT

MEASUREMENTS (cm)

(CALF) _____LT_____RT

(ANKLE) _____LT_____RT

(LENGTH) _____LT_____RT

COMPRESSION LEVEL

30-40 mmHg ☐ LT ☐ RT

40-50 mmHg ☐ LT ☐ RT

FREQUENCY OF CHANGE

MONTHLY ☐ LT ☐ RT

OTHER: _____ ☐ LT ☐ RT

INSURANCE COVERAGE

DOES THE PATIENT HAVE A DEBRIDED OR SURGICALLY CREATED OPEN VENOUS STASIS ULCER? ☐ YES ☐ NO

ADDITIONAL ITEMS ☐SALINE ☐GLOVES ☐COTTON TIP APPLICATORS ☐SKIN PREP ☐ADHESIVE REMOVER ☐STERILE WATER

(SECTION 4) SUPPLY ASSESSMENT

DOES THE PATIENT CURRENTLY HAVE ANY OF THE REQUESTED PRODUCT(S) AT HOME? ☐**YES** ☐**NO**

*IF **YES,** LIST THE QUANTITY REMAINING OF **EACH** PRODUCT THE PATIENT CURRENTLY HAS IN THE NOTES SECTION.*

(SECTION 5) NOTES

(SECTION 6) AUTHORIZATIONS

IS THE PATIENT REQUESTING COORDINATION OF CARE? ☐**YES** ☐**NO**

(THE PATIENT HAS CHOSEN PRISM TO ASSIST IN PROVIDING THE REQUESTED CARE BY EITHER; PROVIDING PRODUCT, VERIFYING INSURANCE BENEFITS, BILLING FOR SERVICE(S) OR COORDINATING CARE SHOULD DIRECT SERVICE NOT BE AN OPTION.)

(SECTION 7) PROVIDER SIGNATURE

_____ **MILROY FLEARY, MD (NPI:1821055682)** _____ **PETER MOLUCA, DPM (NPI:1285683508)**

PROVIDER'S NAME: _____ ***(OR SELECT FROM ABOVE)*** ***SIGNATURE:*** _____

PROVIDER'S NPI: _____ ***(OR SELECT FROM ABOVE)*** ***DATE:*** ____/ ____/ ____

VERSION SWO *0420*