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


GALAXY MEDICAL SUPPLY

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## (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** | | | |
| **WOUND FILLER** | | | |
| **WOUND COVER** | | | |
| **SPECIALITY DRESSING** | | | |
| **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

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