Clinic Name			
Clinic Phone		Clinic Fax	
Patient Name			
Date of birth		Telephone	
Insurance Name		Policy ID	

Order Date:	

Have the wounds been debrided?	YES	NO

FAX # 1-330-425-4355

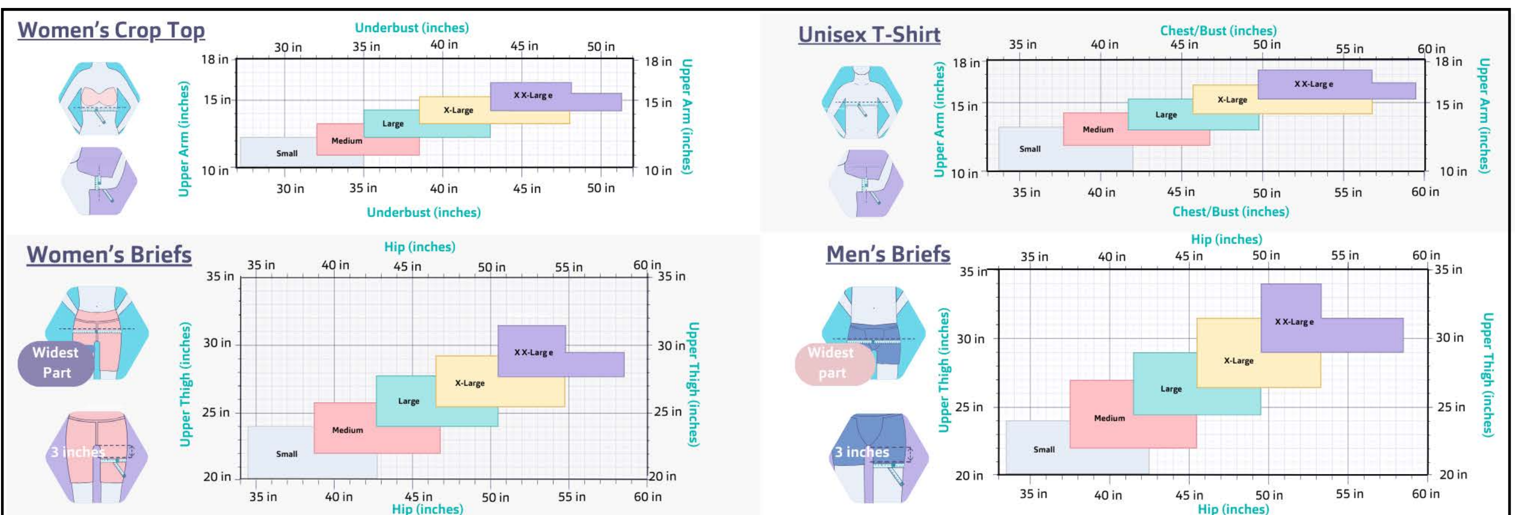
Fax with Patient Information Sheet

Phone # 1 -800-321-0591

AE Name	AE ID #

ICD 10	L98.499	L98.419	Other:

	ICD 10 or wound description	Wound Thickness		Location	Size(LxWxD) cm	Drainage			
W1		Partial	Full			N	L	M	H
W2		Partial	Full			N	L	M	H
W3		Partial	Full			N	L	M	H
W4		Partial	Full			N	L	M	H
W5		Partial	Full			N	L	M	H



Woundcare Products Required *(please check mark size and indicate quantity to dispense for garments)*

Base layer supplies	HidraWear Online Sizing Portal	HidraWear Baselayer Selection- *Please Review the sizing Chart/Portal for optimal fit*						Wound 1	Wound 2	Wound 3	Wound 4	Wound 5
		Womens Crop Top	SM	M	L	XL	XXL					
		Unisex T-Shirt	SM	M	L	XL	XXL					
		Women's Briefs	SM	M	L	XL	XXL					
		Men's Briefs	SM	M	L	XL	XXL					

Hidrawear Dressing Selection *(please indicate frequency of change and check product type required per wound)*

Dressing Supplies	Frequency of Change	Units Per Change					Quantity to be dispensed
		Wound 1	Wound 2	Wound 3	Wound 4	Wound 5	
Superabsorbent 3"x 5"	D or W						
Superabsorbent 3.5" x 7.5"	D or W						

Duration of need:	90 Days	________ Days (Frequency of change and duration of need will define quantity to be dispensed)

√	Practitioner Name NPI#	Practitioner Name NPI#	Practitioner Name NPI#	Practitioner Name NPI#	Practitioner Name NPI#	Practitioner Name NPI#	Treating Practitioner MUST check mark their respective box

SIGNATURE

I attest by my signature that it is my intention for the prescription to remain valid until the diagnosis described is resolved or otherwise directed by the signer. The requested supplies are medically necessary and the wound(s) has/have been debrided and/or surgically created or modified. I have instructed the patient on how to use the supplies being requested.

Practitioner Signature:		Date: Signed	