Reliable RESPIRATORY

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PATIENT INFORMATION

Name:_____

Date of Birth: _____

Address:_____

City:_____ ZIP:_____

Phone #:_____

Diagnosis:_____

Is patient receiving home health OR outside assistance in the home? **Y** or **N**

INSURANCE INFORMATION

Primary Insurance:_____

ID:_____

PHYSICIAN INFORMATION

Name:_____

NPI:_____

Address:_____

City:_____ ZIP:_____

Phone #:_____

Fax #:_____

VERIFICATION: I certify I am treating the patient named above and am ordering these supplies based on my exam and treatment of the patient. I affirm the supplies are medically reasonable and necessary. I have notes, on this form, my findings about the patients wound(S) and supply needs. I keep documentation about my treatment of the patient and will make it available upon request.

Signature:_____

Date:_____

REQUIRED WOUND INFO (circle choices and fill in blanks)

	Wound 1 II III IV P F	Wound 2 II III IV P F	Wound 3 II III IV P F	Wound 4 II III IV P F
Size (LxWxD)				
Location				
Drainage	min. mod. heavy	min. mod. heavy	min. mod. heavy	min. mod. heavy
Ever Debrided	(Yes) or No	(Yes) or No	(Yes) or No	(Yes) or No
Days Needed	30 60 (90)	30 60 (90)	30 60 (90)	30 60 (90)
Change Frequency				

CUSTOMIZED DRESSING ORDERS

Product	Size/Style (In inches unless otherwise specified)	Drainage (required)	Units (per month, required)	Wound # 1	2	3	4
ALGINATES							
calcium alginate / rope	2x2 4x5 3/4x12	mod. – heavy	Up to 30				
medihoney / silver alginate	2x2 4x5 3/4x12	mod. – heavy	Up to 30				
COLLAGENS							
cellerate / stimulen	powder	any	up to 30g				
collagen	2x2 4.34 sq. in.	any	up to 12				
silver collagen	2x2 4x4	any	up to 12				
DRESSINGS							
ABD Pad	5x9 8x10	mod. – heavy	Up to 30				
antimicrobial gauze roll / sponge	4" roll 2x2 4x4	any	Up to 60				
gauze roll / gauze sponge	4" roll 2x2 4x4	any	Up to 60				
hydrocolloid	2x2 4x4	low – mod.	Up to 12				
non-adherent dressing	3x3 3x8	any	Up to 30				
transparent film	2x3 4.25 x 4.25 6x8	no – min.	Up to 12				
xeroform	2" 4"	any	Up to 30				
FOAMS							
bordered foam	2x2 3x3 4x4	mod. – heavy	Up to 12				
foam / silver foam	2x2 4x5	mod. – heavy	Up to 12				
GELS							
anasept gel	3 oz. tube	no – min.	3 oz.				
honey gel	1.5 oz. 3 oz. tube	no – min.	3 oz.				
silver sept gel	1.5 oz. 3 oz. tube	mod. – heavy	3 oz.				
TAPES							
paper / silt / transparent roll	1" 2" 3" rolls	any	2 per wound				
retention tape rolls	2" 4" 6" rolls	any	1 per wound				

COMPRESSION (circle choices and fill in blanks)

LEG	LOCATION	LENGTH	LEVEL	WRAP
Right or Left	Ankle or Calf		30 – 40mmHg 40 – 50mmHg	Juxtalite Farrow Basic

STOCKINGS: ❑Medi Plus ❑Medi Comfort ❑UlcerCare ❑Relief ❑Mediven Dual Layer ❑ Other:_____

Is there an 'Active Venous Leg Ulcer'? **Yes** or **No**

Please Fax the completed form and patient records to 781.987.8206 or email to orders@reliablerespiratory.com