

OP Complex Wound Care Referral



Place Patient Label
Inside This Box

***** This section refers to the entire plan. If individual orders need a different interval, please indicate in each section below***** Version 07/2021

Date of Infusion: _____ Lead Physician _____

Patient Name: _____ Date of Birth: _____

Patient SSN (if available): _____ Contact Number: _____

Insurance Name: _____ Policy Number: _____

Secondary Insurance: _____ Policy Number: _____

Diagnosis Code: _____ Precertification: Initiated Complete

Diagnosis Code Description: _____ Location to be Performed:

- Moore Regional Hospital (MRH)
- Montgomery Memorial Hospital (MMH)

Interval _____ Day _____ of every _____ month Next Due Date _____

Minimum Separation _____ days / weeks (circle one) Duration: Until discontinued _____ Treatments

Until _____

DRESSING CHANGE and SITE Interval Duration

Change dressing _____

Left side wound location: _____ Left arm Left hand Left leg Left foot

Left heel _____

Right side wound location: _____ Right arm Right hand Right leg Right foot

Right heel _____

Wound Location: Right _____ Left _____

Other Wound Locations: _____ Facial Scalp Sacral _____

CLEANSE WOUND

Normal saline _____

Cleanse with soap and water _____

Other: _____

WOUND CARE MEDICATION

Wound dressing gel (medihoney) -024297 _____

silver (SILVASORB) topical gel _____

silver sulfADIAZINE (SILVADENE) 1 % cream
topical (top) _____

cadexomer iodine (IODOSORB) 0.9 % gel
topical (top) _____

Provider Signature: _____ **Date:** _____ **Time:** _____

OP Complex Wound Care Referral

Page 2 of 2

Place Patient Label
Inside This Box

WOUND CARE MEDICATION *(continued)* Interval Duration

sodium hypochlorite (DAKINS QUARTER STRENGTH) 0.125%
topical (top) _____ _____

WOUND CARE PACKING

Gauze packing strips 1/2" _____ _____
 Gauze packing strips 1/4" _____ _____
 Gauze packing strips with Iodoform 1/2" _____ _____
 Gauze packing strips with Iodoform 1/4" _____ _____

WOUND CARE COVER

Dressing-mepilex _____ _____
 Gauze _____ _____
 Dressing Aquacel AG _____ _____
 Abdominal pads _____ _____
 White petrolatum bandage
topical (top) _____ _____
 Non-adherent bandage sponge
topical (top) _____ _____

WOUND VAC PUMP AND SUPPLIES

Wound Vac Type: KCI Wound Vac Prevena Incision Wound Vac
Size: Small Dressing (000906) Ulta Med Dressing (143349)
 Medium Dressing (001765) Wound Vac Cannister w/Gel System (001816)
 Large Dressing (001780) Pump (90067)
 Large Dressing White Foam (019906) Other _____

Suction Setting: 175 mm Hg 150 mm Hg 125 mm Hg 75 mm HG 50 mm Hg
 Continues Intermittent

For Scheduling Fax Forms to: (910) 715-1177.

Provider Signature: _____ Date: _____ Time: _____

* May be used as EPIC Downtime Form