FirstHealth OF THE CAROLINAS

Place Patient Label Inside This Box

OP Simple Wound Care Referral

3POREF001

***** 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	________	________
NURSING COMMUNCIATION		
☐ Other: ______________________	________	________
WOUND CARE MEDICATION		
☐ Wound dressing gel (medihoney) -024297	________	________
☐ silver (SILVASORB) topical gel	________	________
☐ silver sulfADIAZINE (SILVADENE) 1 % cream topical (top)	________	________

Provider Signature: ______________________ **Date:** __________ **Time:** __________

* May be used as EPIC Downtime Form

FirstHealth
MOORE REGIONAL HOSPITAL

OP Simple Wound Care Referral

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WOUND CARE MEDICATION *(continued)*	Interval	Duration
☐ cadexomer iodine (IODOSORB) 0.9 % gel topical (top)	________	________
☐ 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)	________	________

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

Provider Signature: ______________________________ **Date:** ____________ **Time:** ____________

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