DERMATOLOGY PRODUCT ORDER FORM

AdaptHealth Patient Care Solutions Inc.

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INTERNAL USE
Rep # ______
Ref # ______
Tracking ID # ______

PLEASE PROVIDE A FACESHEET WITH PATIENT DEMOGRAPHICS WITH INITIAL ORDER

PATIENT

First Name ______ Last Name ______ ❑ M ❑ F DOB ______
Address ______ Phone ______ Alternate Phone ______
City ______ State ______ Zip ______ Email ______
PRESCRIPTION VALID FOR: ❑ 30 days ❑ 60 days ❑ 90 days **START DATE** ____ / ____ / ____ **DISPENSE:** ❑ 30 day supply ❑ 2 week supply **# OF REFILLS:** ____

REF

Referral ______
Contact ______ Phone ______
How would you prefer to be contacted: ❑ Phone ______ ❑ Email ______ ❑ Fax ______

DIAG

ICD-10 DIAGNOSIS CODE (REQUIRED)
PERCENT OF BODY COVERED IN EB WOUNDS

DISPENSING ORDER INFORMATION

ALGINATE DRESSING		QTY
❑ Calcium Alginate	❑ 2x2 ❑ 4x4 ❑ 4x8 ❑ Rope	
❑ Silver Alginate	❑ 2x2 ❑ 4x5 ❑ 4¼x4¼ ❑ Rope	
COLLAGEN		**QTY**
❑ Endoform	2x2	
❑ Prisma Hexagon	❑ 4.34" ❑ 19.1"	
COMPRESSION DRESSING		**QTY**
❑ Coban/Coflex	❑ 1" ❑ 2" ❑ 3" ❑ 4" ❑ 6"	
FOAM DRESSING		**QTY**
❑ Biatain Soft-Hold	❑ 6x6	
❑ Biatain Silicone Border	❑ 3x3 ❑ 4x4 ❑ 5x5 ❑ 6x6	
❑ Biatain Silicone Lite Border	❑ 3x3 ❑ 4x4 ❑ 5x5	
❑ Bordered Foam	❑ 2x2 pad ❑ 4x4 pad ❑ 4x6 pad	
❑ Hydrofera BLUE Ready	❑ 4x5 ❑ 8x8	
❑ Mepilex Foam	❑ 4x4.8 ❑ 4x8 ❑ 6x6 ❑ 8x8	
❑ Mepilex Border	❑ 3x3 ❑ 4x4 ❑ 6x6 ❑ 6x8	
❑ Mepilex Lite	❑ 2x3 ❑ 4x4 ❑ 6x6 ❑ 8x20	
❑ Mepilex Lite w/Border	❑ 1.6x2 ❑ 2x5 ❑ 3x3 ❑ 4x4 ❑ 6x6	
❑ Mepilex Transfer	❑ 6x8 ❑ 8x20	
❑ Polymem	❑ 3x3 ❑ 5x5 ❑ 6.5x7	
❑ Polymem AG	❑ 4.25x4.25 ❑ 6.5x7.5	
❑ Restore Foam Non Adhesive	❑ 4x4 ❑ 6x8	
❑ Restore Foam Silver	❑ 4x4	
HYDROCOLLOID DRESSING		**QTY**
❑ Duoderm CGF	❑ 4x4 ❑ 6x6	
❑ Duoderm Extra Thin CGF	❑ 4x4 ❑ 6x6	
❑ Duoderm Signal CGF	❑ 4x4 ❑ 5½x5½	
❑ Hydrocolloids Thin	❑ 2x2 ❑ 4x4 ❑ 6x6	
❑ Hydrocolloids Thick	❑ 2x2 ❑ 4x4 ❑ 6x6	

GAUZE		QTY
❑ Adaptic	❑ 3x3 ❑ 3x8	
❑ Bioguard Roll Gauze	❑ 2" ❑ 3" ❑ 4"	
❑ Gauze	❑ 2x2 ❑ 4x4 ❑ 4x8	
❑ Gauze AMD	❑ 2x2 ❑ 4x4	
❑ Iodoform Packing Gauze	❑ ¼" ❑ ½" ❑ 1"	
❑ Kerlix Roll Gauze	❑ 3" ❑ 4" (AMD ❑)	
❑ Mesalt	❑ 2x2 ❑ 3x3 ❑ 8x8 ❑ Ribbon	
❑ Non Woven Gauze	4x4 (200 per/sleeve)	
❑ Roll Gauze Conform	❑ 1" ❑ 2" ❑ 3" ❑ 4" ❑ 6"	
❑ Telfa	❑ 3x4 (AMD ❑) ❑ 3x8 (AMD ❑)	
❑ Vaseline Gauze	❑ 3x9 ❑ 3x18 ❑ 3x36 ❑ 6x36	
❑ Xeroform	❑ 4x4 ❑ 5x9	
RETENTION DRESSING		**QTY**
❑ Tubifast Stretch	❑ Red ❑ Green ❑ Blue ❑ Yellow ❑ Purple	
❑ Tubifast Gloves (Private Pay Only)	Size:	
❑ Tubifast Socks (Private Pay Only)	One Size	
❑ Spandage (sizes 2-8, 10,11)	Size:	
MISCELLANEOUS		**QTY**
Tape: ❑ Paper Tape ❑ Cloth Tape ❑ Plastic Tape	❑ 1" ❑ 2"	
❑ Medipore Tape	❑ 2" ❑ 4"	
❑ Hypafix Tape	❑ 2" ❑ 4"	
	❑ ¾"x118" ❑ 1½"x59"	
❑ Safe N Simple Silicone	1"	
Gloves: ❑ Vinyl ❑ Nitrile	❑ SM ❑ MED ❑ LG	
TRANSPARENT DRESSING		**QTY**
❑ Tegaderm	❑ 2.3x2.7 ❑ 4x4¾ ❑ 6x8 ❑ 8x12	
CONTACT LAYER		**QTY**
❑ Mepitel	4x7"	
❑ Restore Flex	❑ 4x5" ❑6x8"	
OTHER DRESSINGS		**QTY**

DOCTOR

❑ ______ NPI # ______ Email ______ Physician ❑ ______ # ______ Email ______
Address: ______ Phone: ______ Fax: ______ Email: ______

I certify that I am the physician identified on this form. I have reviewed the Physician's Written Order. Any statement on my letterhead attached hereto has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge. I certify that the patient/caregiver is capable and has successfully completed training or will be trained on the proper use of the products prescribed on this Written Order. The patient's record contains supporting documentation that substantiates the utilization and medical necessity of the products listed, and physician notes and other supporting documentation will be provided to AdaptHealth Patient Care Solutions upon request. I understand any falsification, omission or concealment of material fact in that section may subject me to civil or criminal liability. A copy of this order will be retained as part of the patient's medical record.

X Physician Signature ______ (Signature and Date stamps are not acceptable.)
Physician Name ______
X Date ______ (Signature and Date stamps are not acceptable.)

This fax message and any attachments may contain confidential information. If you are not the intended recipient and have received this message in error, please inform sender and delete the contents without copying, distributing or forwarding. By faxing this form you are acknowledging that the patient is aware that an AdaptHealth Patient Care Solutions Representative may be contacting them for any additional information to process this order. Thank you.

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