Byram HEALTHCARE®

Referral #

Customer Service **(877) 742-1972** **Fax** **(800) 642-4639**

Patient

☐ Re-order ☑ Patient Info Attached

Order Date ___/___/___ ___ of ___

Name (L) _____ (F) _____

Ordered by _____

DOB ___/___/___

Pt. Cell Phone _____

Pt. email _____

Phone _____

Dr. / Prescriber

☐ _____ _____ _____ ☐ _____ _____ _____ ☐ _____ _____ _____

By signing this form, I confirm the physician signature corresponds to the name and NPI detailed above and that I am prescribing the items and quantities listed below.

Signature X _____ **Date** _____

Duration of Need - 3 months unless indicated otherwise

Other _____ **(mths)**

Wound Location

	Days Supply 15	Days Supply 30	Diagnosis - ICD.10	Drainage Dry	Drainage Lt	Drainage Mod	Drainage Hvy	Dimensions (cm's) Length	Dimensions (cm's) Width	Dimensions (cm's) Depth	Thickness Part	Thickness Full
1	☐	☐		☐	☐	☐	☐				☐	☐
2	☐	☐		☐	☐	☐	☐				☐	☐
3	☐	☐		☐	☐	☐	☐				☐	☐
4	☐	☐		☐	☐	☐	☐				☐	☐

Amount per dressing change equals one unless stated otherwise.

Order Guide - please be sure the chart notes contain medical justification to support this order & specify the type of debridement (sharp, autolytic, enzymatic, mechanical, etc.)

Debridement Date: ☐ Yes ☐ No ___/___/___

Full Thickness Indicate Brand		Circle Dressing Size			Drainage Guidelines	Freq. (up to)	Wound # 1	2	3	4
ABD Sterile		5 x 9			Mod to Heavy	Daily	☐	☐	☐	☐
Alginate	_____ Ag ☐	2 x 2	4 x 5	Rope	Mod to Heavy	Daily	☐	☐	☐	☐
Collagen	_____ Ag ☐	2 x 2	4 x 4	7 x 7	Lite to Mod	Daily	☐	☐	☐	☐
Super Absorb Pad	_____	3 x 3	4 x 4	6 x 10	Mod to Heavy	Daily	☐	☐	☐	☐
Foam Silicone	_____ Ag* ☐	2 x 2	4 x 5*	6 x 6*	Mod to Heavy	3/week	☐	☐	☐	☐
Foam Silicone	_____	4 x 8	6 x 6	6 x 8	Mod to Heavy	3/week	☐	☐	☐	☐
Foam Silic w/Brd	_____ Ag ☐	4x4, 2x2 pad		6x6, 4x4 pad	Mod to Heavy	3/week	☐	☐	☐	☐
Partial to Full Thickness & Secondary Dressings										
Hydrocolloid		4 x 4	6 x 6	6 x 8	Lite to Mod	3/week	☐	☐	☐	☐
Conform Bandage	Non-str ☐	3"	4"				☐	☐	☐	☐
Roll Gauze Sterile	Non-str ☐	4"	AMD ☐				☐	☐	☐	☐
Other				☐	Dispense as Written		☐	☐	☐	☐

Ancillary Items

Sterile Gauze, Unit Dose Saline and NS Gloves ☐ Check to Order

Tape ☐ Paper ☐ Waterproof ☐ Silk 1" 2" Hypafix 2" 4" Qty (rolls): _____

Compression - Only covered with open venous stasis ulcer

DX1 _____ DX2 _____

	mmHg	Ankle	Mid-Calf	Heel/Back Knee	Style	Brand
Right	☐ 30-40 ☐ 40-50	___ cm	___ cm	___ cm	☐ Calf ☐ Open ☐ Above	☐ CompreFlex Lite* ☐ ReadyWrap ☐ Juzo ☐ JuxtaLite HD* ☐ JuxtaLite* ☐ Farrow*
Left	☐ 30-40 ☐ 40-50	___ cm	___ cm	___ cm	☐ Ankle ☐ Closed ☐ Below	☐ Carolon ☐ Sigvaris ☐ Dual Layer

* One per six (6) months per leg.

Version 3/17/2021