HANDI MEDICAL SUPPLY

Standard Written Order: Wound Care Supplies

Prescriber Information

Clinic/Location Name:
Prescriber Name:
Prescriber Address:
Prescriber City State Zip:
Prescriber Phone:
Prescriber Fax:
Prescriber NPI:

Patient Information

Patient Name:
Patient Address:
Patient City State Zip:
Phone:
DOB:
Primary Insurance:
Handi Customer Number:
Doc ID#:

Diagnosis (ICD-10)

Description	Dressing size	Dispensing Qty	Frequency of Change

1. **Ordered Date:** _____ 2. **Length of Need:** _____
   Leaving blank presumes Lifetime (99 months)
3. **Date of wound evaluation: ___/___/_____**
4. **Please complete the following questions, and attach Wound Evaluation Notes for all wounds:**

Wound #1 Location: _____ Has debridement been attempted? ☐ Yes ☐ No
Type: ☐ Surgical ☐ Pressure Injury ☐ Venous Stasis Ulcer ☐ Burn ☐ Other:_____
Length_____cm Width_____cm Depth_____cm Stage/Thickness:_____ Drainage:_____
Primary Dressing Type:_____ Secondary Dressing Type:_____

Wound #2 Location: _____ Has debridement been attempted? ☐ Yes ☐ No
Type: ☐ Surgical ☐ Pressure Injury ☐ Venous Stasis Ulcer ☐ Burn ☐ Other:_____
Length_____cm Width_____cm Depth_____cm Stage/Thickness:_____ Drainage:_____
Primary Dressing Type:_____ Secondary Dressing Type:_____

Wound #3 Location: _____ Has debridement been attempted? ☐ Yes ☐ No
Type: ☐ Surgical ☐ Pressure Injury ☐ Venous Stasis Ulcer ☐ Burn ☐ Other:_____
Length_____cm Width_____cm Depth_____cm Stage/Thickness:_____ Drainage:_____
Primary Dressing Type:_____ Secondary Dressing Type:_____

5. **Information completed by:** _____
   Name / Credentials

6. _____ _____
   Physician/NP/PA/Medical Practitioner Signature Date

: Signer must match Prescriber Information at the top of this form, or be updated below

Print New Prescriber Name: _____ NPI: _____

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