Please Fax Completed Orders To: 1-888-649-5810
Questions? Please Call: 1-888-854-0888

BROCK MEDICAL
BROCKMEDICAL.COM

Facility ______________________________

Order Start Date ______________________________

Patient's Name ______________________________

Date of Birth ______________________________

Patient's Phone ______________________________

Is Patient Being Seen by Home Health? ☐ Yes ☐ No

Ordering Provider ______________________________

Ordering Provider NPI ______________________________

Facility Phone ______________________________

Facility Fax ______________________________

Patient is Evaluated as: ☐ Inpatient ☐ Outpatient

Wound Assessment and Documentation

	Wound # ________	Wound # ________	Wound # ________	Wound # ________
ICD-10CM Code				
Reason for Dressing	☐ Surgical Wound ☐ Debridement - Surgical ☐ Debridement - Mechanical ☐ Debridement - Autolytic ☐ Debridement - Chemical ☐ Other: ________	☐ Surgical Wound ☐ Debridement - Surgical ☐ Debridement - Mechanical ☐ Debridement - Autolytic ☐ Debridement - Chemical ☐ Other: ________	☐ Surgical Wound ☐ Debridement - Surgical ☐ Debridement - Mechanical ☐ Debridement - Autolytic ☐ Debridement - Chemical ☐ Other: ________	☐ Surgical Wound ☐ Debridement - Surgical ☐ Debridement - Mechanical ☐ Debridement - Autolytic ☐ Debridement - Chemical ☐ Other: ________
Wound Type				
Stage	☐ I ☐ II ☐ III ☐ IV ☐ Unstageable ☐ Deep Tissue Injury	☐ I ☐ II ☐ III ☐ IV ☐ Unstageable ☐ Deep Tissue Injury	☐ I ☐ II ☐ III ☐ IV ☐ Unstageable ☐ Deep Tissue Injury	☐ I ☐ II ☐ III ☐ IV ☐ Unstageable ☐ Deep Tissue Injury
Wound Size (LxWxD) Should be reflective of documentation in medical record	______ x ______ x ______	______ x ______ x ______	______ x ______ x ______	______ x ______ x ______
Thickness	☐ PT ☐ FT	☐ PT ☐ FT	☐ PT ☐ FT	☐ PT ☐ FT
Wound Location	________ ☐ LT ☐ RT	________ ☐ LT ☐ RT	________ ☐ LT ☐ RT	________ ☐ LT ☐ RT
Drainage	☐ None ☐ Light ☐ Moderate ☐ Heavy	☐ None ☐ Light ☐ Moderate ☐ Heavy	☐ None ☐ Light ☐ Moderate ☐ Heavy	☐ None ☐ Light ☐ Moderate ☐ Heavy

Wound Care Products - Advanced Dressings, Fillers, Pads, and Covers

Product	Duration of Need	Primary Secondary Other	Quantity *(if more than one at a time)*	Wound # ____ Frequency of Change	Wound # ____ Frequency of Change	Wound # ____ Frequency of Change	Wound # ____ Frequency of Change
	☐ 15 ☐ 30 ☐ 60 ☐ 90	☐ Primary ☐ Secondary ☐ Other					
	☐ 15 ☐ 30 ☐ 60 ☐ 90	☐ Primary ☐ Secondary ☐ Other					
	☐ 15 ☐ 30 ☐ 60 ☐ 90	☐ Primary ☐ Secondary ☐ Other					
	☐ 15 ☐ 30 ☐ 60 ☐ 90	☐ Primary ☐ Secondary ☐ Other					
	☐ 15 ☐ 30 ☐ 60 ☐ 90	☐ Primary ☐ Secondary ☐ Other					

Compression Stockings

Please check the appropriate options for this patient.

Side: ☐ Right ☐ Left **Color:** ☐ Beige ☐ Black

Open Venous Ulcer: ☐ Yes ☐ No

Class: ☐ Class II 30-40mmHg ☐ Class III 40-50mmHg

LEG MEASUREMENTS

	Ankle	Calf	Length
Right			
Left			

Notice to Ordering Provider: Provider must order only those supplies that are medically necessary for the patient, given his or her clinical condition. Provider must submit the diagnosis information for all products ordered and medical necessity should be documented in the patient's medical record. Medicare, Medicaid and other third-party payers will only pay for products that meet the payer's coverage criteria and are reasonable and necessary to treat or diagnose the patient. I also attest that the documentation of the medical necessity of all products ordered has been documented in the patient's medical record.

. Ordering Provider Signature ______________________________ Date ______________

A signed valid order must be received.