INNOVATIVE OUTCOMES

DETAILED WRITTEN SUPPLY ORDER

FAX: 501-904-3626
Phone: 866-714-7118

PATIENT

NAME:		**PHONE:**	
Address:		**EMAIL:**	
CITY/STATE		**D.O.B.**	**RX DATE:**
ZIP CODE		**PLEASE INCLUDE PATIENT'S FACE SHEET, WOUND NOTES AND TREATMENT PLAN WHEN AVAILABLE.**	

Is this patient currently being seen by Home Health? ☐ YES ☐ NO

Does this patient currently reside in a Long Term Care facility? ☐ YES ☐ NO

Duration of need is 90 days unless otherwise specified **DURATION OF NEED:** ☐ **90 (DAYS)** ☐ **OTHER** _____ **(DAYS)**

Category	DRAINAGE (Ex.: MOD/HVY)	BRAND / DESCRIPTION	Wound #	Wound #	Wound #	Wound #

COMPRESSION LEVEL

_____ 30-40 mmHg _____ 40-50 mmHg _____ OTHER:

SIZE & DEPTH (L X W X D) (in cm)

☐ (cm) ☐ (in)

(CALF) ☐ LT _____ ☐ RT _____

(ANKLE) ☐ LT _____ ☐ RT _____

(LENGTH) ☐ LT _____ ☐ RT _____

Compression Stockings/Wraps

SINGLE LAYER STOCKING ☐ LT ☐ RT

DUAL LAYER STOCKING ☐ LT ☐ RT

COMPRESSION WRAP ☐ LT ☐ RT

FREQUENCY OF CHANGE (Ex.: DAILY; 3X/WEEK)				
DESCRIPTION / DIAGNOSIS				
SIZE & DEPTH (L X W X D) (in cm)				
LOCATION (Ex.: R 1st Toe)				
THICKNESS (Full)				
DRAINAGE (Min, Mod, Heavy)				
CHECK IF DEBRIDED DATE: ☑				

ACCEPTABLE DEBRIDMENT METHODS: SHARP ENZIMATIC AUTOLYTIC BLUNT MECHANICAL ULTRA SONIC LAVAGE

SPECIAL INSTRUCTIONS:

REFERRING CLINIC

NAME		**CONTACT:**	
ADDRESS			
CITY/STATE/ZIP			
PHONE			
FAX			

Authorization	☑	TREATING PHYSICIAN	
THE PATIENT IS REQUESTING COORDINATION OF CARE ☐ **YES** ☐ **NO** (*THE PATIENTHAS CHOSEN INNOVATIVE OUTCOMES TO ASSIST IN THE PROVIDING THE REQUESTED CARE BY EITHER; PROVIDING PRODUCT, VERIFYING INSURANCE BENEFITS, BILLING SERVICE(S) OR COORDINATING CARE SHOULD DIRECT SERVICE NOT BE AN OPTION.)*	☐		☐
	☐		☐
	☐		☐
	☐		☐

X **PHYSICIAN'S SIGNATURE**

SIGNATURE:_____

X **PATIENT'S SIGNATURE**

SIGNATURE:_____ DATE: _____