STYMCO MEDICAL

(844) 552-8813 • www.STYMCO.com

TO PLACE THIS ORDER...
Fax to (813) 922-3152 OR
Email to verify@stymco.com

☑ **Completed Prescription Form** | **Patient Insurance & Address** | **Relevant Medical Notes**

Wound Care Prescription Form

PATIENT/FACILITY INFORMATION

Patient Name: _____ D.O.B _____

Facility Name: _____

Facility City/State: _____

Facility Phone: _____

Facility Fax: _____

Case Manager: _____

PRESCRIPTION INFORMATION

Prescription Date: _____

Order Type: ☐ NEW *(Replace existing)* ☐ ADD *(Supplement existing)*

Frequency: ☐ 15 DAYS ☐ 30 DAYS *(Default if not specified)*

Does patient have Diabetes? ☐ YES ☐ NO

Patient being seen by Home Health Services? ☐ YES ☐ NO

Patient trained to apply requested dressings? ☐ YES ☐ NO

COMPRESSION STOCKINGS *(Must have open venous ulcer to qualify)*

Leg Side: ☐ Left Leg ☐ Right Leg

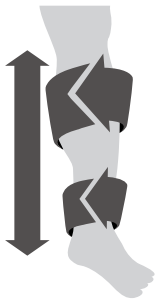
Toe Type: ☐ Open Toe ☐ Closed Toe

Compression: ☐ 30-40mmHg ☐ 40-50mmHg

LEG CIRCUMFERENCE:

Left Calf: _____ *(cm)*

Right Calf: _____ *(cm)*



Left Ankle: _____ *(cm)*

Right Ankle: _____ *(cm)*

LEG LENGTH *(Heel to back of knee)*: _____ *(cm)*

STOCKING TYPE	ICD-10
Single Layer Stocking	
Dual Layer Stocking	
Juxta Lite	
Medi Dual Layer	
Other:	

WOUND CARE PRODUCTS

PRODUCT TYPE	CHANGE FREQ.	WOUND NUMBER 1	2	3	4
Collagen w/ Silver					
Collagen					
Calcium Alginate w/ Silver	*Daily*				
Calcium Alginate	*Daily*				
Hydrocolloid	*Every 3 Days*				
Hydrogel Tube					
Foam Dressing	*Every 3 Days*				
Foam Dressing w/ Border	*Every 3 Days*				
Foam Dressing w/ Silver	*Every 3 Days*				
ABD Pad	*Daily*				
Antimicrobial Gauze Sponge	*Daily*				
Conforming Roll Gauze	*Daily*				
Gauze ☐ 2" x 2" ☐ 4" x 4"	*Daily*				
Sterile Gauze ☐ 2" x 2" ☐ 4" x 4"	*Daily*				
Tape (Size:_____)	*Daily*				
Nitrile Gloves ☐ SM ☐ MD ☐ LG					
Other:					

WOUND ASSESSMENT

WOUND	ICD-10	DATE OCCURRED	CHANGE FREQ.	SIZE *(L x W x D)*	LOCATION *(e.g. Left Ankle)*	EXUDATE
1						N L M H
2						N L M H
3						N L M H
4						N L M H

PROVIDER APPROVAL

I attest by my signature that it is my intention for this prescription to remain valid until the underlying disease/diagnosis described above is resolved or otherwise directed by the signer.

NPI#: _____ **Date:** _____

PRINT NAME: _____

SIGNATURE: _____

PATIENT APPROVAL

I request that payment of my insurance benefits be made to STYMCO Medical, LLC for any supplies or services they provide me. I am responsible for any balance due that is not covered by my insurance. I understand that any product received in my home cannot be returned if opened. I authorize any holder of my medical information to release to STYMCO Medical, LLC any information needed to determine benefits payable for these supplies or services.

PATIENT SIGNATURE: _____

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