Wound Care Intake Form

Northborough, MA: **Toll free** (855) 880-1091 **Toll free fax** (844) 265-0265

www.AllCarePlusPharmacy.com

PATIENT INFO

Patient Name

Address

City, State, Zip

Phone

Social Security

Date of Birth

Gender ◯ Male ◯ Female

PRESCRIBER INFO

Group/Hospital

Address

City, State, Zip

Phone

Fax

Preparer Name/Office Contact

INSURANCE: PLEASE FAX COPY OF PRESCRIPTION CARD & MEDICAL CARD FRONT & BACK

CLINICAL INFORMATION

Are any of wounds a burn? ◯ **Yes** ◯ **No**

Diagnosis Code: _____

Please list any known allergies to medication or other substances:

_____

Wound Care Plan: **Wound Location**

*Wound #1:☐ _____ cm X ____cm _____

*Wound #2:☐ _____ cm X ____cm _____

*Wound #3:☐ _____ cm X ____cm _____

*Wound #4:☐ _____ cm X ____cm _____

*Wound #5:☐ _____ cm X ____cm _____

*Wound #6:☐ _____ cm X ____cm _____

*Wound #7:☐ _____ cm X ____cm _____

*Wound #8:☐ _____ cm X ____cm _____

Other: _____

PHYSICIAN INFORMATION

Prescriber Name: NPI:

Prescriber Name: NPI:

Prescriber Name: NPI:

Prescriber Name: NPI:

Prescriber Name: NPI:

Prescriber Name: NPI:

Prescriber Name: NPI:

Prescriber Name: NPI:

Prescriber Name: NPI:

Prescriber Name: NPI:

Prescriber Name: NPI:

Prescriber Name: NPI:

Prescriber Name: NPI:

PRESCRIPTION INFORMATION

DRUG	DOSAGE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ **Collagenase SANTYL® Ointment**	(250/units/g)-30g/90g	Apply to wound once daily (or more frequently if the dressing becomes soiled) for _____ days	Dispense qty sufficient for _____ days	_____

Physician Signature: _____ Date: _____

I authorize AllCare Plus Pharmacy and its representatives to act as an agent to initiate and execute the insurance prior authorization process.