



# Wound Care Intake Form

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

[www.AllCarePlusPharmacy.com](http://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
<b>Diagnosis Code:</b> _____	
Please list any known allergies to medication or other substances: _____	
<b>Wound Care Plan:</b>	<b>Wound Location</b>
*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: _____

**PRESCRIPTION INFORMATION**

DRUG	DOSAGE/STRENGTH	DIRECTIONS	QUANTITY	REFILLS
<b>Collagenase SANTYL® Ointment</b>	(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.**  
IMPORTANT NOTICE: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the transmitted material. In no event should the material be read or retained by anyone other than the named addressee, except by express authority of the sender to the named addressee. This is a patient enrollment form for the above mentioned therapies. Patients have the right to use the Pharmacy of their choice, if AllCare Plus Pharmacy is the Pharmacy of choice, please follow up with a call in, electronic, faxed or mailed prescription to AllCare Plus Pharmacy, 50 Bearfoot Road, Northborough, MA 01532. (Phone) 1 855 880 1091 (Fax) 1 844 265 0265