YALE SURGICAL CO.

ORTHOTICS, PROSTHETICS & PEDORTHICS SINCE 1923

627 Chapel Street, New Haven, CT 06511
(p) 203-777-2396 • (f) 203-782-4966

Referral # _____

PATIENT Re-order ☐ Face Sheet Attached ☑ Order Date _____ ____ of ____

Name (L) _____ (F) _____ Ordered By _____

DOB ____/____/____ Is the patient being seen by a home health agency? Yes ☐ No ☐ Fax Confirmation ☐ Mail Confirmation ☐

Diabetes? Yes ☐ No ☐ Acc't Phone _____ Email _____

By signing this form, I confirm the physician signature corresponds to the name and NPI detailed to the right and that I am prescribing the items and quantities listed below.

Physician Name _____

Signature X _____ **Date** _____

NPI _____

Duration of need: 3 months unless indicated otherwise. Other: _____ (mths)

WOUND (Only need on new orders or when plan of care changes.)

		Dimensions (cms) ✓			Drainage ✓				Thickness ✓	
Location	Type or ICD .9 code	Length	Width	Depth	Dry	Lt	Mod	Hvy	Part	Full
1)										
2)										
3)										
4)										

Starter Kits

SILVERCEL® NA 4.25x4.25 (JJ900404CSK)
SILVERCEL® NA 2x2 (JJ900202CSK)
Mepilex 4x5 (SC294090SK)

Wnd#	1	2	3	4
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐

Kits: Contain 3 primary dressings, may also contain 3 secondary dressings and 2" tape.

SUPPLIES

Drainage | One dressing per change unless otherwise noted | 30 Days Supply | 30-Day Allow Amt | Change Frequency, i.e., QD

Dry	Lt	Mod	Hvy	**Full Thickness**	**Brand**	**Size** (choose from drop down)	30-Day Allow Amt	wnd #1	wnd #2	wnd #3	wnd #4
		•	•	Alginate	Sorbion Sachet®	choose	31				
		•	•		Manuka Honey Light	choose	31				
		•	•	Alginate	Drawtex® Hydroconductive	choose	31				
		•	•	Alginate	Restore Ag	choose	31				
		•	•	Alginate	SILVERCEL®	choose	31				
		•	•	Foam	Hydrofera Blue	choose	12				
		•	•	Foam	Mepilex®	choose	12				
		•	•	Foam w/Bord	Mepilex® Border	choose	12				
		•	•	ORC/Collagen	PROMOGRAN PRISMA®	choose	31				
		•	•	Collagen	Helix	choose	31				
•	•			Hydrogel	SOLOSITE® Gel	choose	3 oz				
•	•			Hydrogel	SilvaSorb® Gel	choose	3 oz				
				Partial to Full Thickness							
•	•	•	•	Padding	SurePress®	choose	60				
•	•			Hydrocolloid w/Bord	DuoDERM Signal®	choose	12				
	•	•		Hydrocolloid	Triad™ Hydrophilic Paste	choose	12 oz				
•	•	•	•	Impregnated Gauze	Vaseline®	choose	31				
•	•	•	•	Impregnated Gauze	ADAPTIC®	choose	31				
•	•			Transparent Film	Tegaderm™	choose	12				
Secondary				ABD Pad, Sterile	Curity™	choose	31				
Dressings				Conform Band., St.	Dermacea™	choose	60				
				Bordered Gauze	Medline®	choose	31				
				Roll Gauze, St.	Kerlix™ AMD/Kerlix™ St	choose	31				
OTHER:											

Ancillary Items: (check to order) Sterile Gauze, Unit Dose Saline & NS Gloves ☐ Tape ☐ Paper ☐ Waterproof ☐ Silk 1" ☐ 2" ☐ Hypafix® 2" ☐ 4" ☐ Qty (rolls) _____

Patient Authorization Release of Information and Assignment of Benefits - My signature on the line below authorizes any of the following. I certify that the information given by me in applying for payment under Medicare (Title XVIII of the Social Security Act) and / or any other medical insurance is correct. I authorize the release to Yale Surgical any medical information including the diagnosis that may be necessary for insurance payment. I authorize benefits payable to Yale Surgical on assigned claims. I authorize Yale Surgical to submit claims to Medicare and or/any other insurance carrier. I agree to assume responsibility for any balance for supplies furnished to me by Yale Surgical not approved by my insurance policy. This includes but is not limited to deductibles, coinsurance, and non-covered items. I authorize that photo copies shall be used as valid originals.

Patient Signature (Initial Order Only) X _____ Date _____

Patient Email _____