



CLOCK MEDICAL SUPPLY, INC.
SOLVING PROBLEMS / DELIVERING SOLUTIONS

901 INDUSTRIAL BLVD
PHONE: 1-620-221-0550

PO BOX 620
TOLL FREE: 1-800-362-1314

WINFIELD, KS 67156-0620
FAX: 1-620-221-7460

FAX

To:

From:

Fax:

Pages: (including cover page)

Phone:

Date:

RE:

Patient DOB:

WOUND CARE ORDER

To Whom It May Concern:

Please review the following order and complete the information where the ➡ indicates.

Also verify that all the information is correct or make corrections accordingly.

THANK YOU

Please complete the following:

Is the patient currently on Home Health

Doctor's Notes / Wound dictation

Physician's Signature and the Date

And FAX to 620-221-7460

Thank you for your time and help

HAVE A GREAT DAY!

IMPORTANT: This facsimile transmission contains confidential information, some or all of which may be protected health information as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule. This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient (or an employee or agent responsible for delivering this facsimile transmission to the intended recipient), you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender by telephone (number listed above) to arrange the return or destruction of the information and all copies.

WOUND ORDER



901 Industrial Blvd, PO Box 620
Winfield, KS 67156
Phone: 620-221-0550
Toll Free: 800-362-1314
Fax: 620-221-7460

Patient Name: _____
Address: _____
City/ST/Zip: _____
Phone: _____
Start Date: _____ DOB: _____



Is this patient currently on Home Health? ☐ Yes ☐ No

IF YES, Home Health Name: _____

1) Wound Location _____

Type: ☐ Pressure Ulcer ☐ Arterial or Venous Stasis ☐ Surgical ☐ Diabetic ☐ Burn

Stage: (if stageable) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Non Stageable

Burn: Degree _____ % of Body _____

Type of Surgery: _____ Date of Surgery or Injury: _____

Thickness: ☐ Partial ☐ Full ☐ None Type of Debridement: _____

Drainage Amt: ☐ None ☐ Scant ☐ Small ☐ Mod ☐ Heavy

Size: Length: _____ cm x Width: _____ cm x Depth: _____ cm

Frequency of Change: _____ Estimate of Duration: _____

Supplies Requested	Qty Requested	Size	Amount per Change
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2) Wound Location _____

Type: ☐ Pressure Ulcer ☐ Arterial or Venous Stasis ☐ Surgical ☐ Diabetic ☐ Burn

Stage: (if stageable) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Non Stageable

Burn: Degree _____ % of Body _____

Type of Surgery: _____ Date of Surgery or Injury: _____

Thickness: ☐ Partial ☐ Full ☐ None Type of Debridement: _____

Drainage Amt: ☐ None ☐ Scant ☐ Small ☐ Mod ☐ Heavy

Size: Length: _____ cm x Width: _____ cm x Depth: _____ cm

Frequency of Change: _____ Estimate of Duration: _____

Supplies Requested	Qty Requested	Size	Amount per Change
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____



Physician Signature: _____ Date: _____



Physician's Name: _____ Fax #: _____

New orders are required if a new dressing is added/quantity is increased/or every 3 months for each dressing being used even if the quantity used has remained the same or decreased.