CLOCK MEDICAL SUPPLY, INC.
SOLVING PROBLEMS / DELIVERING SOLUTIONS

901 INDUSTRIAL BLVD PO BOX 620 WINFIELD, KS 67156-0620
PHONE: 1-620-221-0550 TOLL FREE: 1-800-362-1314 FAX: 1-620-221-7460

FAX

To:

From:

Fax:

Pages: 2 **(including cover page)**

Phone:

Date: 09/23/2015

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 acccordingly.

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!

WOUND ORDER

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www.ClockMedical.com
Solving Problems / Delivering Solutions

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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 tl quantity used has remained the same or decreased.