HANDI MEDICAL SUPPLY

Standard Written Order: Wound Care Supplies

Prescriber Information

Clinic/Location Name:
Prescriber Name:
Prescriber Address:
Prescriber City State Zip:
Prescriber Phone:
Prescriber Fax:
Prescriber NPI:

Patient Information

Patient Name:
Patient Address:
Patient City State Zip:
Phone:
DOB:
Primary Insurance:
Handi Customer Number:
Doc ID#:

Diagnosis (ICD-10)

Description	Dressing size	Dispensing Qty	Frequency of Change

1. **Ordered Date:** _____ 2. **Length of Need:** _____
   Leaving blank presumes Lifetime (99 months)
3. **Date of wound evaluation: ___/___/_____**
4. **Please attach most recent Wound Evaluation Notes for all wounds.**
5. **Comments:**

6. _____ _____
   Physician/NP/PA/Medical Practitioner Signature Date

: Signer must match Prescriber Information at the top of this form, or be updated below

Print New Prescriber Name: _____ NPI: _____

  Tel: 651-644-9770 or 800-514-9979 2505 University Avenue West, St. Paul, MN 55114