



Wound Care Order Form

Fax: 907-561-9221

Phone: 907-561-9220

Orders@MyTritonSupply.com

Patient Name: _____ Clinic: _____

Referring Provider: _____

Customer Service Rep: _____

In order for Triton Supply to process a patient's order, we need the following documentation sent: Copy of the PATIENT FACE SHEET, signed (AOB), ORDER SIGNED BY PHYSICIAN

DRESSING (specify brand & size) Primary/Secondary				Req. Drainage	Wound 1	Wound 2	Wound 3	Wound 4
Powder Collagen	Endoform	Promogran/AG	P/S	Any	☐	☐	☐	☐
Alginate/AG	AG/Rope		P/S	Mod/Heavy	☐	☐	☐	☐
Foam Border	Non Border		P/S	Mod/Heavy	☐	☐	☐	☐
Hydrogel Gauze	Silver Gel		P/S	No/Low	☐	☐	☐	☐
Hydrocolloid			P/S	Low/Mod	☐	☐	☐	☐
Petrolatum Gauze	Xeroform		P/S	Any	☐	☐	☐	☐
Gauze/AMD	Telfa		P/S	Any	☐	☐	☐	☐
Conform 2" 3" 4"	Roll Gauze 2" 4"		P/S	Any	☐	☐	☐	☐
ABD Pad 5x9 8x10	Hydrofera		P/S	Mod/Heavy	☐	☐	☐	☐
Border Gauze			P/S	Any	☐	☐	☐	☐
Film Dressing 2.75 4.75 6x8			P/S	Any	☐	☐	☐	☐
Tape			P/S	Any	☐	☐	☐	☐
Other			P/S					
Compression: ☐ Medi ☐ Jobst ☐ Sigvaris ☐ Juxta-Lite				Frequency of Use				
mmHg: ☐ 15-20 ☐ 18-25 ☐ 20-30 ☐ 30-40 ☐ 40-50 ☐ 50-60				Drainage				
Measurements: Thigh only needed for thigh high _____ R Ankle _____ L Ankle _____ R Calf _____ L Calf _____ R Length _____ L Length _____ Thigh Circ. _____ Thigh Circ. Other Details _____				Location				
				Dimensions				
				Thickness	Partial/Full	Partial/Full	Partial/Full	Partial/Full
				Number of Refills				

Have the wound(s) ever been debrided? Yes ☐ No ☐ Saline? Yes ☐ No ☐ Prognosis ☐ Poor ☐ Fair ☐ Good ☐ Excellent

☐ Wound is Surgical Is Patient on Home Health? Yes ☐ No ☐ Diagnosis:

☐ Starter Kit given matches Tx ☐ Patient has been instructed on how to use product

Providers Name: _____ Fax: _____ Phone: _____

Signature: _____ Date: _____ NPI: _____

Please add email for electronic signature if provider is unable to sign Email: _____

Assignment of Benefits (AOB)

I request that payment of my insurance benefits be made to Triton Medical Supply for any supplies or services furnished by Triton Medical Supply. I am responsible for any balance due that is not covered by my insurance. I understand any product received in my home, opened or unopened, cannot be returned. I authorize any holder of medical information about me to release to Triton Medical Supply any information needed to determine benefits payable for these supplies or services. Further, I authorize Triton Medical Supply to forward my medical records to the medical professionals in my care and/or make copies of said records. I acknowledge that I have received the policies and procedures and HIPAA information from Triton Medical Supply.

Patient Name: _____ Email: _____

Authorized Signature: _____ Date: _____ Phone: _____

Name of Authorized Representative: _____