Wound Care Order Form

Fax: 602-428-6841
Phone: 480-795-7955
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 Other Details _____ R Ankle _____ L Ankle _____ R Calf _____ L Calf _____ R Length _____ L Length _____ Thigh Circ. _____ Thigh Circ.		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 suppliers 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: _____