

Hand Injury Wound/Scar Hydrogel Sheeting Prescription

PATIENT INFORMATION

Patient Name _____ M / F

Address _____

City _____ State _____ Zip _____

Tel _____ Patient notified of order

Date of Birth _____

Email Address _____

Responsible Party _____ Tel _____

Caregiver _____ Tel _____

Is patient being seen by Home Health Agency? Yes No

Avogel NDC Codes: : (1) 4"x4" sheet; NDC 76170-0104-43
 (2) 8"x8" sheet; NDC 76170-0108-83
 (3) 6"x48" roll. NDC 76170-0164-83

INSURANCE INFORMATION

Primary ins Co _____

ID # _____ Tel _____

Group or Claim # _____

Secondary Insurance Co _____

ID # _____ Tel _____

Referring Agency _____

Address _____

City _____ State _____ Zip _____

Ordering Physician _____

Fax _____ Tel _____

Patient Next Appointment: ____Weeks ____Months

Wound Scar Assessment and Management Summary

DIAGNOSIS: POST-SURGICAL, POST-TRUAMA HAND AND EXTREMITY SCARRING

INITIAL CAUSE OF WOUND: ICD 10 _____

IF BURN WOUND: Initial Depth of burn?: Partial Full

CLOSED WOUND AND SCAR ASSESSMENT:

Wound Location \	Type	Length cm	Width cm	Initial Thickness/Stage
1. L / R	CLOSED			Partial Full
2. L / R	CLOSED			Partial Full
3. L / R	CLOSED			Partial Full

Freq. of Changes : Weekly, Secure with : Surgilast (or equiv) or compression garment.

Instructions : Apply Avogel to wound 18 hours /day; Reuse Avogel dressing for 5-7 days; Replace Avogel 5-7 days

Total Avogel _____ sheets for 30-DAY supply _____; Duration of need: 30 days 60 days 90 days

Assessment Performed By: _____; Date: _____
 Signature and Title

Physician's Signature (Required) _____ Date: _____