Aven Home Health Services
Physician Order for Wound Care

Physician/Clinician: Please complete all of the following information. Incomplete wound documentation could result in a delay of your patient's order.

PATIENT

Patient Name: _____ ☐ Male ☐ Female SS#: _____-_____-_____

Address: _____ Date of Birth: _____

City, State, Zip: _____ Phone: _____

WOUND INFORMATION

Diagnosis (ICD9): _____

Evaluation Dates: **Current Eval** ___/___/___ Initial_____ | **30-60 Day** ___/___/___ Initial _____ | **60-90 Day** ___/___/___ Initial _____

Prognosis (circle one) **:** Good Fair Poor Other**:** _____ **Length of Need** (1-99 months; 99=lifetime) **:** _____

Reason for use of dressing: Surgical Wound Wound Debridement Moist Healing Other: _____

Location of wound(s): _____

	Stage (I, II, III, IV)	**Size** (Unit: _____) (length x width x depth)	**Drainage** (none, light, moderate, heavy)
Wound 1	_____	_____ x _____ x _____	_____
Wound 2	_____	_____ x _____ x _____	_____
Wound 3	_____	_____ x _____ x _____	_____
Wound 4	_____	_____ x _____ x _____	_____

Wound #	**Type and Size of Dressing**	**Qty per Change**	**Frequency of Change**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

HEALTH INS.

Primary Insurance Name: _____ Insurance Phone #: _____

Policy #: _____ Auth #:_____ Insured Person's Name: _____

PHYSICIAN & CLINICIAN

Physician Printed Name: _____ Phone: _____

Physician Signature: _____ **Date:** _____ NPI #: _____

☐ **I attest that I have "read back" this order to physician to assure accuracy**

Printed Name/Title of Clinician Receiving orders: _____

Clinician Signature **:** _____ Date**:**_____

AHHS

Please complete form in full, sign all areas indicated, and return to Aven Home Health Services:

FAX TO: (818) 380-0143 CALL TO VERIFY RECEIPT AT: (818) 380-0853

MAIL TO: 14044 Ventura Boulevard, Suite 305, Sherman Oaks, CA 91423