BINSON'S Medical Equipment & Supplies Since 1953

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Clear Form

ACHC ACCREDITED

WOUND CARE TREATMENT PLAN

PATIENT NAME:	ACCOUNT #
ADDRESS:	DOB:
CITY/STATE/ZIP:	PHONE #
TYPE OF WOUND:	Amputation Burns Skin Graft/Flap Open Surgical Wound Pressure Ulcer Venous Ulcer Diabetic Ulcer Arterial Ulcer
DIAGNOSIS/OTHER:	

WOUND INFORMATION	WOUND 1	WOUND 2	WOUND 3	WOUND 4
MEASUREMENTS - CENTIMETERS TO INCHES MULTIPLY BY .394 *** INCHES TO CENTIMETERS MULTIPLY BY 2.54				
Location				
Length	CM	CM	CM	CM
Width	CM	CM	CM	CM
Depth	CM	CM	CM	CM
Undermining/Tunneling	CM	CM	CM	CM
Pressure Ulcer Stage	1 2 3 4	1 2 3 4	1 2 3 4	1 2 3 4
Partial/Full Thickness	PT FT	PT FT	PT FT	PT FT
Amt of Drainage	MIN MOD HVY	MIN MOD HVY	MIN MOD HVY	MIN MOD HVY
Type of Debridement	Surg Mech Chem Auto	Surg Mech Chem Auto	Surg Mech Chem Auto	Surg Mech Chem Auto
Frequency of Changes	each day	each day	each day	each day
Duration of Need	30 days 90 days	30 days 90 days	30 days 90 days	30 days 90 days

DRESSINGS – PER CHANGE

WOUND	Dressing	Qty	Dressing	Qty	Dressing	Qty	Dressing	Qty
Primary								
Secondary								
Secondary								
Secondary								
Secondary								

Other supplies required for dressing changes

(non-waterproof) _____ Rolls of _____" Paper Tape or Similar

(waterproof) _____ Rolls of _____" Medipore Tape or Similar

DRESSINGS – 30 DAY QUANTITY

Item Description	Size	Qty per Change		Qty to be Shipped
			x30	
			x30	
			x30	
			x30	
			x30	

DISPENSED AS WRITTEN OR SUBSTITUTE:

NURSE SIGNATURE:		DATE:
PHYSICIAN NAME:		
ADDRESS w/CITY, STATE, ZIP:		
PHONE:	FAX:	NPI #
PHYSICIAN SIGNATURE:		DATE:

PHONE: MICHIGAN 1-888-246-7667 FLORIDA 1-866-928-0003

FAX: 1-586-755-2322 1-407-691-3021