Sound Health MEDICAL

QUICK START PROGRAM

NEXT DAY DELIVERY

CMN

Fax: 866.213.4464 Questions

Please Call: 888.958.2960

Full Assignment Accepted

Patient Name: _____ Clinic: _____

Reffering Provider: _____

Customer Service Rep:

In order for Sound Health to process your/a patient's order, we need the following documentation faxed:
*Copy of the PATIENT FACE SHEET *signed (AOB) (at bottom) *ORDER SIGNED BY PHYSICIAN

DRESSING- (specify brand and 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 2.75² 4.75² 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:**	Location			
_____ R Ankle _____ L Ankle	Dimensions			
_____ R Calf _____ L Calf	Thickness	Partial /Full	Partial /Full	Partial /Full
_____ R Length _____ L Length	Number Of Refills			
_____ Thigh Circ. _____ Thigh Circ.				

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 Sound Health Medical Supply for any supplies or services furnished to be by Sound Health 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 Sound Health Medical Supply any information needed to determine benefits payable for these supplies or services. Further, I authorize Sound Health 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 HIPPA information from Sound Health.

Patient Name: _____ Email: _____

Authorized Signature: _____ Date: _____ Phone: _____

Name Of Authorized Representitive: _____

(*If Patient is Unable to Sign*)