

Patient Information

Patient Name:		Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Address:		City:	State:	Zip:
Phone Number:	Alternate Phone Number:		Language:	
Social Security Number:		E-Mail:		
Allergies:				<input type="checkbox"/> NKDA
<input type="checkbox"/> Pick Up / Ship to: <input type="checkbox"/> Patient <input type="checkbox"/> Office <input type="checkbox"/> Alternative Address:				

Prescription Insurance: Please fax copy of prescription insurance card (front and back)

Prescriber Information

Practice Name:				
Office Contact:				
Practice Address:		City:	State:	Zip:
Phone Number:		Fax Number:		

Home Health Referral Information

Referring Agency:		Referring Provider/Nurse:	
Referring Agency Address:		Referring Agency Phone Number:	
Referring Agency City:		Referring Agency Fax:	
Referring Agency State:	Referring Agency Zip:	Referring Agency Notes:	

Clinical Information

Diagnosis code:	Is this a burn patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
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Comments/Notes:

Wound Care Plan	Wound Location	Prescriber
<input type="checkbox"/> Wound 1 _____ cm x _____ cm		<input type="checkbox"/> _____ NPI: _____
<input type="checkbox"/> Wound 2 _____ cm x _____ cm		<input type="checkbox"/> _____ NPI: _____
<input type="checkbox"/> Wound 3 _____ cm x _____ cm		<input type="checkbox"/> _____ NPI: _____
<input type="checkbox"/> Wound 4 _____ cm x _____ cm		<input type="checkbox"/> _____ NPI: _____
<input type="checkbox"/> Wound 5 _____ cm x _____ cm		<input type="checkbox"/> _____ NPI: _____
<input type="checkbox"/> Wound 6 _____ cm x _____ cm		<input type="checkbox"/> _____ NPI: _____
<input type="checkbox"/> Other:		<input type="checkbox"/> _____ NPI: _____

Prescription Information

Medication	Dose	Directions	Quantity	Refills
<input type="checkbox"/> Collagenase Santyl® Ointment	250 units/g	Apply a nickel thick layer to wound once daily (or more frequently as the dressing becomes soiled)	<input type="checkbox"/> 7 day supply <input type="checkbox"/> 14 day supply <input type="checkbox"/> 30 day supply <input type="checkbox"/> Other:	

Prescriber Signature and Date (Please sign and date below)

_____ Date _____ Dispense as Written _____ Date _____

"I authorize Curexa™ and its representatives to act as an agent to initiate and execute the insurance prior authorization process and receive forms on the prescriber's behalf. I certify that the above therapy is medically necessary and the above information is accurate to the best of my knowledge"

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