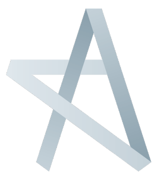

ARGENCIS

Experts in Patient Home Delivery Since 1994

P.O.Box 271195
Oklahoma City, OK 73137
o. 800-745-2215 | f. 866-399-9338
www.argencis.com

**TO AVOID DELAYS, PLEASE FAX THIS FORM, PT FACESHEET, & SUPPORTING RECORDS TO 866-399-9338.
INFORMATION ON THIS FORM MUST MATCH INFORMATION IN THE PERMANENT MEDICAL RECORD.**

PHYSICIAN AND FACILITY INFO		PATIENT INFO	
PHYSICIAN		NAME	
FACILITY		DOB	

	SEVERITY+DRAINAGE	WOUND #1	WOUND #2	WOUND #3
1. *OPTIONAL* CHOOSE CONTACT LAYER (MUST BE APPLIED DIRECTLY TO WOUND BED)				
WOUND CONTAC LAYER Ag? Y / N	N/A	☐	☐	☐
2. CHOOSE ONE PRIMARY DRESSING PER WOUND (MUST BE APPLIED DIRECTLY TO WOUND BED *OR* ATOP CONTACT LAYER)				
ALGINATE/GELLING FIBER Ag? Y / N	ST3 or FT + Mod-Hvy	☐	☐	☐
COLLAGEN [ ] SHEET [ ] GEL Ag? Y / N	ST3 or FT + Min-Mod	☐	☐	☐
COLLAGEN POWDER/PARTICLES	ST3 or FT + Min-Mod	☐	☐	☐
FOAM, NON-BORDER	ST3 or FT + Mod-Hvy	☐	☐	☐
HYDROCOLLOID PASTE	ST2 or PT + Min-Mod	☐	☐	☐
HYDROGEL GEL	ST3 or FT + None-Min	☐	☐	☐
OINTMENT/TOPICAL (HONEY, TAO, ETC)	NONCOVERED/SELF-PAY	☐	☐	☐
PETROLATUM GAUZE	ANY	☐	☐	☐
TRANSPARENT FILM	ST2 or PT + None-Min	☐	☐	☐
*OTHER:		☐	☐	☐
3. CHOOSE ONE SECONDARY DRESSING PER WOUND (MUST BE APPLIED DIRECTLY OVER PRIMARY DRESSING)				
ABD PAD	ST3 or FT + Mod-Hvy	☐	☐	☐
ALGINATE/GELLING FIBER Ag? Y / N	ST3 or FT + Mod-Hvy	☐	☐	☐
BORDERED GAUZE	ANY	☐	☐	☐
FIBER GELLING SUPERABSORBER	ST3 or FT + Mod-Hvy	☐	☐	☐
FOAM, BORDERED	ST3 or FT + Mod-Hvy	☐	☐	☐
FOAM, NON-BORDERED	ST3 or FT + Mod-Hvy	☐	☐	☐
HYDROCOLLOID SHEET	ST2 or PT + Min-Mod	☐	☐	☐
HYDROGEL SHEET	ST3 or FT + None-Min	☐	☐	☐
*OTHER:		☐	☐	☐
4. CHOOSE A METHOD OF SECUREMENT (IF SECONDARY IS NON-BORDERED)				
KERLIX + ACE		☐	☐	☐
KERLIX + COHESIVE WRAP		☐	☐	☐
KERLIX + ELASTIC NET		☐	☐	☐
KERLIX + TAPE		☐	☐	☐
TAPE ONLY		☐	☐	☐
*OTHER:		☐	☐	☐
5. FREQUENCY OF DRESSING CHANGE		qDay EOD 3xWkly	qDay EOD 3xWkly	qDay EOD 3xWkly

COMPRESSION GARMENTS

- ☐ Gradient Compression Wrap
- ☐ 30-40 2-Layer
- ☐ 40-50 2-Layer
- ☐ 30-40 Single Layer OT
- ☐ 30-40 Single Layer CT

MEASUREMENTS (cm)

	LLE	RLE
Ankle (Smallest):		
Calf (Largest):		
Length:		

Replace: [ ] Monthly [ ] 6-Months [ ] Other:

WOUND CARE ANCILLARIES NEEDED (SELECT UP TO 3):

- ☐ SALINE
- ☐ GLOVES
- ☐ BULK 4x4s
- ☐ SKIN PREP
- ☐ Q-Tips
- ☐ OTHER:

Notes/Special Instructions: ____

____

PHYSICIAN or CLINICIAN SIGN: ________________________ Date: ______________

Print (if not Physician): ________________________

☐ Check for 15-day supply