



SANTYL ORDER FORM

Please Fax Orders to : 954-304-9703

FACILITY INFORMATION

Facility Name:	Facility Contact:
	Facility Phone:
	Facility Fax:

PATIENT INFORMATION:

Last Name:	First and Middle Name:	Date of Birth:
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WOUND CARE PLAN

Wound #	Wound Size	Location	Grams Needed	Prescription Order				
Wound 1 _____ cm x _____				Collagenase Santyl Ointment 250 units/g				
Wound 2 _____ cm x _____				Apply to wound area once daily (or more frequently as the dressing becomes soiled)				
Wound 3 _____ cm x _____				<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 70%; padding: 2px;">Total Grams requested:</td> <td style="padding: 2px;">Refills (CIRCLE)</td> </tr> <tr> <td></td> <td style="text-align: center;">1 2 3 4 5 6 7 8 9 10 11</td> </tr> </table>	Total Grams requested:	Refills (CIRCLE)		1 2 3 4 5 6 7 8 9 10 11
Total Grams requested:	Refills (CIRCLE)							
	1 2 3 4 5 6 7 8 9 10 11							
Wound 4 _____ cm x _____				Days Supply:				
Wound 5 _____ cm x _____				Note to Pharmacy:				
Wound 6 _____ cm x _____								

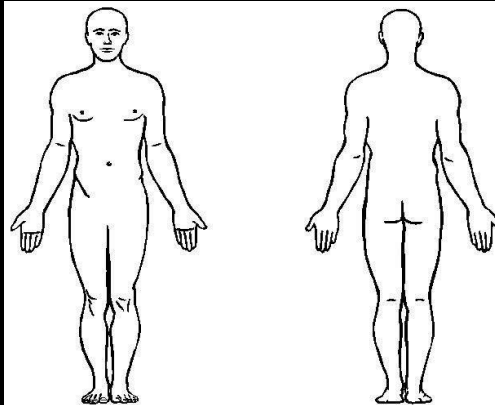
PHYSICIAN INFORMATION:

Prescriber Name:	Prescriber NPI:	Prescriber phone:
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Prescriber signature:	Date:
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WOUND CALCULATION GUIDE

Wound area	30 days therapy
1-6 cm ²	30 g
7-12 cm ²	60 g
14-16 cm ²	90 g
18-21 cm ²	120 g
24 cm ²	150 g
25-28 cm ²	150 g
30-35 cm ²	180 g
36 cm ²	210 g
40 cm ²	210 g
42 cm ²	210 g
48-49 cm ²	270 g
56 cm ²	300 g
64 cm ²	330 g



Please Indicate the location of the wound

DISCHARGE INFORMATION

Discharge Date:	Ship To:	<input type="checkbox"/> Facility	<input type="checkbox"/> Home	
Discharge Location:				Discharge Contact:
				Discharge Phone:
				Discharge Fax:

Santyl Dosing Calculator is Available on Santyl.com