



STAR CARE PHARMACY

"The First Wealth is Health"

175-20 Hillside Avenue • Jamaica, NY 11432

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Toll Free: 888-216-STAR (7827)

WOUND CARE

Date: _____ Attn: _____

Ship to Patient Physician Office Nurse/Training

Patient Name _____
 Address _____ Suite# _____
 City _____ State _____ Zip _____
 Home Tel _____ Work Tel _____
 Cell _____ Email _____
 Date of Birth _____ SS# _____
 Male Female Weight _____ Height _____

Prescriber's Name _____
 License# _____ DEA# _____
 NPI# _____ UPIN# _____
 Practice Name _____
 Office Contact _____
 Address _____ Suite# _____
 City _____ State _____ Zip _____
 Tel _____ Fax _____

Insurance Information (Complete or attach copies of cards)

Primary Insurance: _____ Insured's Name: _____
 ID#: _____ City: _____ State: _____ Phone: () _____ - _____
 Group #: _____ Employer: _____

Clinical Information - Please send all available chart notes including lab results

Diagnosis code: _____ Is this a burn patient? Yes No

Comments/Notes:

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

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:	
<input type="checkbox"/> Regranex® Gel	0.01%	Apply a thin layer to affected area. Cover with saline moistened gauze for 12 hours. After 12 hours, remove medication using saline or water. Cover ulcer with new saline moistened dressing (without gel). Repeat daily	<input type="checkbox"/> 7 day supply <input type="checkbox"/> 14 day supply <input type="checkbox"/> 30 day supply <input type="checkbox"/> Other:	

Prescriber's Signature (signature required. NO STAMPS) _____ Date _____

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