Stoll's Pharmacy, Inc.
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Surgical Dressings

Dear Physician,

Stoll's Pharmacy, Inc. is in receipt of your order placed by you or your staff to provide services to your patient listed below. The information below is a written confirmation of this order. Your cooperation in completing this form is required to insure that this patient receives their full medical benefits. Please fill in all the necessary information as well as modify any incorrect entries on this form.

Pt. Name: _____ Birth Date: _____

Address: _____ City/ST/Zip: _____

1) Period of Medical Necessity: Order Start Date: _____

2) A. Estimated length of need: _____ D. _____ New Prescription
   B. Dates From: _____ to _____ E. _____ Renewal Prescription
   C. Patient Last Seen: _____

3) Equipment Prescribed:

4) Diagnosis and Status (**ICD-10-CM Code**): _____

5) Date of Surgical Procedure or Debridement: _____
   Number of Wounds: _____
   Location of Wounds: _____
   Size of Wound: (cm) _____ Length _____Width _____ Depth
   Frequency of Dressing Changes: _____ / Day _____/ Week
   Number of Dressings Per Wound: _____

6) Severity of Condition: ☐ Extreme ☐ Acute ☐ Grave ☐ Infected ☐ Other
   Prognosis: ☐ Good ☐ Guarded ☐ Poor

I, the undersigned certify that the above equipment is medically necessary for this patient's wellbeing. In my opinion, the equipment is both reasonable and necessary in reference to accepted standards of medical practice in treatment of this patient's condition and is NOT prescribed as "convenience equipment.

Physician Name (Please Print):_____ NPI#: _____

Physician Address: _____City/ST/Zip: _____

Physician Signature: _____ Date: _____

PLEASE NOTE: A stamped signature or date is not acceptable