WOUND CARE REFERRAL FORM

www.albertsons.com/specialtycare • Phone: 877.466.8028 • Fax: 877.466.8040

Albertsons Companies Specialty Care

Jewel Osco · Albertsons · SAFEWAY · VONS · ACME · shaw's · star market · PAVILIONS · CARRS · Randalls · Tom Thumb

Patient Information

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F

Phone: _____ Cell Phone: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

ICD-10 Diagnosis Code: _____ Diagnosis: _____

Allergies (please note reaction): _____ ☐ Latex

Current Medications: (list here or attach a medication list): _____

_____

Comorbidities: (list here or attach a list): _____

Prescription Information

INSURANCE INFORMATION - FAX COPY OF PATIENT'S INSURANCE CARD - BOTH SIDES

MEDICATION	STRENGTH	DIRECTIONS	QUANTITY	REFILLS
☐ Regranex (becaplermin)	0.01% Gel	☐ Apply to wound(s) once a day for _____ days. ☐ Apply to wound(s) _____ times per day for _____ days.	☐ 15 grams ☐ ____grams	
☐ Santyl Ointment	250 units/gm	☐ Apply to wound(s) once a day for _____days. ☐ Apply to wound(s)_____ times per day for _____days.	☐ 30 grams ☐ 90 grams ☐ Quantity sufficient per the manufacturer's dosing calculator ☐ ____grams	
☐ Other Medication				

Treatment History: ☐ **New to Therapy** ☐ **Continuation of Therapy**

Wound Care Plan:

☐ Wound #1 _____cm x_____cm Location:_____ ☐ Wound #2 _____cm x_____cm Location:_____

☐ Wound #3 _____cm x_____cm Location:_____ ☐ Wound #4 _____cm x_____cm Location:_____

☐ Wound #5 _____cm x_____cm Location:_____ ☐ Wound #6 _____cm x_____cm Location:_____

☐ Total Body Surface Area (TBSA)_____ Location(s):_____

Prescriber Information

Prescriber Name: _____

State License #: _____ DEA #: _____ NPI: _____

Additional Contact Person Name: _____

Group or Hospital: _____ Phone: _____

Fax: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Prescriber Signature: _____ _____ _____

Product Substitution Permitted | Dispensed as Written | Date

The prescriber is to comply with state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber.

Delivery Information

☐ Ship to Patient ☐ Ship to Prescriber/Clinic ☐ Pick up at Albertsons Companies Pharmacy

Date Medication Needed: _____