C&S MEDICAL SUPPLY

EXTERNAL FIXATOR SPONGE SUPPLY PRESCRIPTION FORM

Date: _____

Patient Name: _____

Address: _____

_____

Date of Birth: _____

Any Known Allergies: _____

Diagnosis Code: _____

Hospital: _____

RX Dispense: _____

☐ Box(es) External Fixtor Sponges (150 per box) (PRN Refills)

☐ Box(es) Sterile Tip Applicators (200 per box) (PRN Refills)

☐ Bactroban Cream 30 gram tube (PRN Refills)

☐ Ilizarov Clips White (30 per pack) (PRN Refills)

☐ Ilizarov Clips Red (10 per pack) (PRN Refills)

☐ Non-Latex Gloves ☐ Small ☐ Medium ☐ Large ☐ X-Large (PRN Refills)

Units used per wound site: 1

Frequency of dressing change: _____

Number of pin (wound) sites: _____

Reason for dressing: _____

REQUESTING PHYSICIAN:

I certify that the above items are medically necessary for the treatment of this patient.

_____ _____

Physician Signature Date

Physician Name:_____

Physician Phone Number:_____

C & S Medical Supply

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