



## SANTYL PRESCRIPTION REFERRAL FORM

NEW PATIENT    CURRENT PATIENT

151 Cochituate Rd | Framingham, MA 01701  
 PHONE: 508-202-9993 | FAX: 508-202-9343 | 844-7-MYVCARE

Patient Name \_\_\_\_\_ SS# \_\_\_\_\_ D.O.B. \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_  Male  Female  
 Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Preferred Language \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
 Patient's Usual Pharmacy \_\_\_\_\_ Patient Notes \_\_\_\_\_  
 ICD-10 Diagnosis \_\_\_\_\_ Is this a burn patient?  Yes  No Allergies: \_\_\_\_\_

Insured's Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Eligible for Medicare  Yes  No If yes, Medicare # \_\_\_\_\_  
 Prescription Card  Yes  No If yes, Carrier: \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_ Policy/Group# \_\_\_\_\_  
 BIN# \_\_\_\_\_ PCN# \_\_\_\_\_ RXID# \_\_\_\_\_ RX Group# \_\_\_\_\_

Prescriber Name \_\_\_\_\_ Practice Name/Office Contact \_\_\_\_\_  
 Street Address \_\_\_\_\_ Suite # \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Prescriber Phone \_\_\_\_\_ Prescriber Fax \_\_\_\_\_ Prescriber Email \_\_\_\_\_

PRESCRIPTION			Please attach copies of patient's insurance cards	
WOUND CARE PLAN	AREA	WOUND LOCATION	PRESCRIBER	NPI#
<input type="checkbox"/> Wound 1 _____ cm x _____ cm	_____ cm <sup>2</sup>		<input type="checkbox"/>	
<input type="checkbox"/> Wound 2 _____ cm x _____ cm	_____ cm <sup>2</sup>		<input type="checkbox"/>	
<input type="checkbox"/> Wound 3 _____ cm x _____ cm	_____ cm <sup>2</sup>		<input type="checkbox"/>	
<input type="checkbox"/> Wound 4 _____ cm x _____ cm	_____ cm <sup>2</sup>		<input type="checkbox"/>	
<input type="checkbox"/> Wound 5 _____ cm x _____ cm	_____ cm <sup>2</sup>		<input type="checkbox"/>	
<input type="checkbox"/> Wound 6 _____ cm x _____ cm	_____ cm <sup>2</sup>		<input type="checkbox"/>	
<input type="checkbox"/> Wound 7 _____ cm x _____ cm	_____ cm <sup>2</sup>		<input type="checkbox"/>	
<input type="checkbox"/> Wound 8 _____ cm x _____ cm	_____ cm <sup>2</sup>		<input type="checkbox"/>	
<input type="checkbox"/> Other _____			<input type="checkbox"/>	
MEDICATION	DIRECTIONS	QTY	REFILLS	COMMENTS
<input type="checkbox"/> <b>COLLAGENASE SANTYL OINTMENT (250 Units/G)</b>	<input type="checkbox"/> Apply a nickel thick layer to wound once daily (or more frequently as the dressing becomes soiled)	<input type="checkbox"/> 30 Day Supply <input type="checkbox"/> 60 Day Supply <input type="checkbox"/> 90 Day Supply <input type="checkbox"/> _____ Day Supply	_____	

This is **not** a valid prescription and is intended for reference only. For providers: **Please send a valid prescription electronically or via fax.**

Prescriber's Signature (no stamps) \_\_\_\_\_ Date \_\_\_\_\_

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