SANTYL PRESCRIPTION REFERRAL FORM

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

☐ NEW PATIENT ☐ CURRENT PATIENT

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#
☐ Wound 1	______ cm x ______ cm	______ cm^2		☐	
☐ Wound 2	______ cm x ______ cm	______ cm^2		☐	
☐ Wound 3	______ cm x ______ cm	______ cm^2		☐	
☐ Wound 4	______ cm x ______ cm	______ cm^2		☐	
☐ Wound 5	______ cm x ______ cm	______ cm^2		☐	
☐ Wound 6	______ cm x ______ cm	______ cm^2		☐	
☐ Wound 7	______ cm x ______ cm	______ cm^2		☐	
☐ Wound 8	______ cm x ______ cm	______ cm^2		☐	
☐ Other ______				☐	

MEDICATION	DIRECTIONS	QTY	REFILLS	COMMENTS
☐ **COLLAGENASE SANTYL OINTMENT (250 Units/G)**	☐ Apply a nickel thick layer to wound once daily (or more frequently as the dressing becomes soiled)	☐ 30 Day Supply ☐ 60 Day Supply ☐ 90 Day Supply ☐ ____ 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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