TODT HILL PHARMACY
SPECIALTY PHARMACY
2110 Richmond Road
Staten Island, NY 10306

Toll Free 844.994.0016
Phone 718.351.7363
Fax 718.351.4972
www.todthillspecialtyrx.com
todthillrx@gmail.com

WOUND CARE REFERRAL / RX FORM

PLEASE INCLUDE ALL
MEDICAL RECORDS AND LABS
PLEASE FAX TO 718.351.4972

PATIENT INFORMATION

Last Name _____ First Name _____ DOB _____

Address _____ City _____ State _____ Zip _____

Gender: ☐ Male ☐ Female Height _____ Weight _____ Social Security # _____

Home Phone _____ Cell _____ Email Address _____

Allergies _____ Emergency Contact Name _____ Phone _____

INSURANCE INFORMATION

Primary Insurance _____ Policy # _____ Group # _____ Phone _____

Policy Holder's Name _____ DOB _____

Secondary Insurance _____ Policy # _____ Group # _____ Phone _____

Policy Holder's Name _____ DOB _____

MEDICATION INFORMATION

☐ **Collagenase SANTYL Ointment** 250 units / gram Quantity sufficient for _____ days Number of Refills: _____

Directions: Apply to wound once a day (or more frequently if the dressing becomes soiled) for _____ days

Primary Diagnosis _____
ICD -10 CODE _____
Secondary Diagnosis _____
ICD - 10 CODE _____
Is patient currently using SANTYL ? ☐ Yes ☐ No
SANTYL is being prescribed to treat burns? ☐ Yes ☐ No

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 _____
☐ Wound #7 _____ cm x _____ cm Location _____
☐ Wound #8 _____ cm x _____ cm Location _____
☐ Other _____ Location _____

☐ Physician _____
NPI _____
☐ Physician _____
NPI _____
☐ Physician _____
NPI _____
☐ Physician _____
NPI _____
☐ Physician _____
NPI _____
☐ Physician _____
NPI _____
☐ Physician _____
NPI _____
☐ Physician _____
NPI _____

Deliver to: ☐ **Patient's Home** ☐ **1st dose to physician's office - remaining to patient home** ☐ **Physician's Office**

PATIENT INFORMATION

Clinic Name _____ Physician Email _____

Address _____ City _____ State _____ Zip _____

Phone _____ Fax _____ Office Contact _____

PRESCRIBERS SIGNATURE

_____ Product Selection Permitted

_____ Dispense as Written

_____ Date