



**LOWER UMPQUA HOSPITAL  
OUTPATIENT NURSING DEPARTMENT  
600 Ranch Road, Reedsport, OR 97467**

**For Referrals:** (541) 271-2163 – Press #3 (all other services) then press # 2 (Referrals)

**For Outpatient Nursing:** (541) 271-2171 ext. 5205

**FAX:** (541) 271-5433

## WOUND CARE ORDERS

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

Patient Phone # \_\_\_\_\_ Patient Weight (Kg) \_\_\_\_\_ Patient Height (cm): \_\_\_\_\_

Patient Allergies \_\_\_\_\_

Provider \_\_\_\_\_ NPI# \_\_\_\_\_

ICD-10 Code (REQUIRED) \_\_\_\_\_ J Code \_\_\_\_\_

Primary Diagnosis \_\_\_\_\_

Secondary Diagnosis \_\_\_\_\_

### INSTRUCTIONS TO PROVIDER:

- *This treatment plan will expire **after 365 days**, at which time new orders will need to be placed.*

### WOUND CARE ORDERS:

- ☐ Evaluate and apply **wound dressing** treatment relevant to wound as needed until wound is closed or needs further medical attention.

- **Wound Location:** \_\_\_\_\_
- **Type of Wound:** \_\_\_\_\_

- ☐ Evaluate and apply **wound vac** relevant to wound as needed until wound is closed or needs further medical attention.

- **Wound Location:** \_\_\_\_\_
- **Type of Wound:** \_\_\_\_\_

- ☐ Evaluate and apply **placental tissue allograft and/or placental extracellular matrix** relevant to wound as needed until wound is closed or needs further medical attention.

- **Wound Location:** \_\_\_\_\_
- **Type of Wound:** \_\_\_\_\_

Date \_\_\_\_\_ Time \_\_\_\_\_ Provider Signature \_\_\_\_\_

*"Statement of Responsibility of Parties: referring Prescriber agrees that in referring patients to Lower Umpqua Hospital Outpatient Nursing Department, the responsibility for the care related to these Outpatient Nursing Therapy Plan orders, as well as administration of any 340B drugs, remains with Lower Umpqua Hospital."*