INSERT LETTERHEAD HERE

DOCUMENTATION OF EXACT ITEM DISPENSED

Patient's Name: _____ DOB: _____

Delivery Address: _____

Patient's Address: _____

Ordering Physician: _____

Other Ordering Physician: _____

Initials Qty

_____ **30** unit(s) (A6196) Alginate or other fiber gelling dressings, wound cover, sterile, pad size 16 sq in or less, each dressing

_____ ____ unit(s) (A6219) Gauze, Non-Impregnated, Sterile, Pad Size 16 Sq. In. Or Less, With any size adhesive border, each dressing

_____ ____ unit(s) (A6220) Gauze, non-impregnated, sterile, pad size more than 16 sq in, but less than or equal to 48 sq in, with any size adhesive border, each dressing

_____ **60** unit(s) (A6402) Gauze, Non-Impregnated, Sterile, Pad Size 16 Aq. In. Or Less, without adhesive border, each dressing

_____ ____ unit(s) (A6252) Specialty absorptive dressing, wound cover, sterile, pad size more than 16 sq in but less than or equal to 48 sq in, without adhesive border, each dressing

_____ ____ unit(s) (A6446) Conforming bandage, non-elastic, knitted/woven, sterile, width greater than or equal to three inches and less than five inches, per yard

_____ ____ unit(s) (A4452) Tape, waterproof, per 18 square inches

_____ **1** unit(s) (A6260) Wound cleanser, any type, any size

Signature for Receipt of Items:_____

Date of Signature and Delivery: _____

Relation to Beneficiary if other than self:_____

OFFICE USE ONLY:

By signing and witnessing, I concur with the Physician's order that the patient has a weakness/deformity of the foot and ankle requiring stabilization and the patient has the potential to benefit functionally.

Dispenser/Witness: _____ Date: _____