



Prescription Support Document

Patient: D.O.B.:

The wound type is: Health & Care Number:

Location: Size:

Has been present for weeks/months.

Treatment History / Other Notes

4 Day Treatment Cycle



Repeat as necessary

Requested Products per Treatment

(see over for BioBag® Size Guide)

Code	Description	QTY
BB50	BioBag® 2.5 x 4 cm	
BB100	BioBag® 4 x 5 cm	
BB200	BioBag® 5 x 6 cm	
BB300	BioBag® 6 x 12 cm	
BB400	BioBag® 10 x 10 cm	
SC	Sudocrem	

Requested Dates of Treatment:

Treatment 1:

Treatment 2:

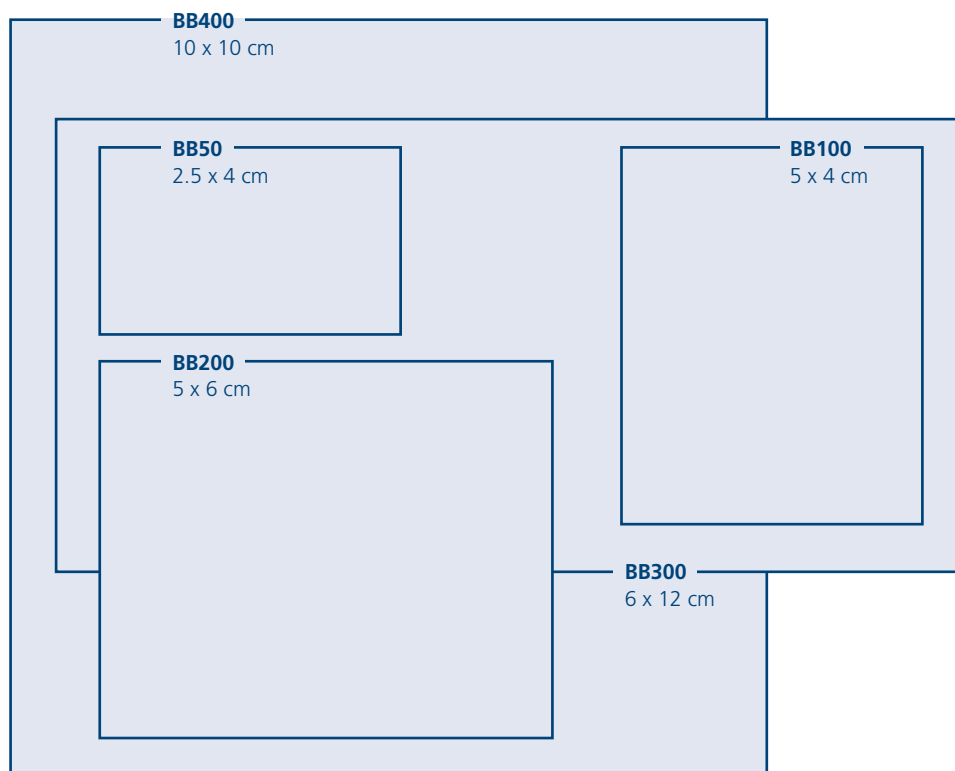
Treatment 3:

Requested by:

Name:

Signature:

BioBag® Size Guide



OUR TEAM ARE HERE FOR YOU

Clinical Helpline: 0345 230 6806

Order: 0345 230 1810

Support: clinicalsupport@biomonde.com

Order: orders@biomonde.com

