Negative Pressure Wound Therapy - Physician's Written Order

Fax form to 1(877) 832-6837

Required Attachments: • All Wound Assessments • History & Physical • Nutritional Evaluation

Start Date:_____ / _____/______

1. PATIENT INFORMATION

Facility: ______________________________ **Discharging to:** **Home** **Nursing Home**

Patient Name: ______________________________ **Date of Birth:** ________________

Patient Address: ______________________________ **City:** ____________ **State:** ______ **Zip:** __________

Duration of Need: 4 months, If other ________ months Are there provisions for adequate nutritional status? YES NO

Was NPWT initiated in an Inpatient setting and is now being continued in the home? YES NO If YES, when did Inpatient NPWT Begin? __________________

Is the patient being treated & evaluated regularly? YES NO

What other therapies have been tried and/or failed to maintain a moist wound environment?

Saline Gauze Absorptive Alginate Hydrocolloid Hydrogel None Other ____________________________

INDICATE ANY CONDITIONS THAT WILL EXCLUDE COVERAGE

Is untreated osteomyelitis present in the wound? YES NO Does patient have necrotic tissue with eschar without attempted debridement? YES NO

Is cancer present in the wound? YES NO Does patient have a fistula to an organ or body cavity within the vicinity of the wound? YES NO

IMPORTANT NOTE FOR ALL ORDERS: All information on this form MUST be supported in the patient's clinical chart and copies of the supportive documentation must accompany this order BEFORE the device will be provided.

2. PRIMARY WOUND TYPE

VENOUS ULCER

Have compression bandages and/or garments been consistently applied? YES NO

Has leg elevation and ambulation been encouraged? YES NO

STAGE III **STAGE IV**

Has the patient been appropriately turned and positioned? YES NO

For trunk or pelvis wounds, has the patient used a group 2 or 3 support surface? YES NO

Has the patient's moisture and incontinence been appropriately managed? YES NO

NEUROPATHIC / DIABETIC ULCER

The beneficiary has been on a comprehensive diabetic management program YES NO

Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities YES NO

ARTERIAL ULCER

Is pressure over wound being relieved? YES NO

SURGICAL WOUND **TRAUMATIC WOUND**

Was the wound encountered in an inpatient setting? YES NO

3. WOUND INFORMATION

Wound #1 Type ____________________________

Wound Location: L R ______________________

Length:________cm Width: _______cm Depth: _______cm

Drainage Amount: None Minimum Moderate Large

If Pressure Ulcer, Stage: 1 2 3 4

If Non-pressure Ulcer, Depth: Skin Fat Muscle Bone

Wound Required Debridement: Yes No Date Debrided ___________

Wound #2 Type ____________________________

Wound Location: L R ______________________

Length:________cm Width: _______cm Depth: _______cm

Drainage Amount: None Minimum Moderate Large

If Pressure Ulcer, Stage: 1 2 3 4

If Non-pressure Ulcer, Depth: Skin Fat Muscle Bone

Wound Required Debridement: Yes No Date Debrided ____________

4. NPWT TREATMENT ORDER

Quantity to Dispense	HCPC	Description	Frequency of Use (Utilizing 1 Pump)
1	E2402	Negative Pressure Wound Therapy Electrical Pump, Portable	Continuous therapy required______ Intermittent therapy required______

WOUND 1				WOUND 2			
Quantity to Dispense Per Month	HCPC	Frequency of Use	Description	Quantity to Dispense Per Month	HCPC	Frequency of Use	Description
15 if other _____*	A6550	1 every 2 days. If other _____ every _____ days	Wound Care Set, for NPWT Electrical Pump, includes all supplies and accessories	15 if other _____*	A6550	1 every 2 days. If other _____ every _____ days	Wound Care Set, for NPWT Electrical Pump, includes all supplies and accessories
10 if other _____*	A7000	1 every 3 days. If other _____ every _____ days	Disposable Canister for Pump	10 if other _____*	A7000	1 every 3 days. If other _____ every _____ days	Disposable Canister for Pump

***If quantities are marked other, please explain:** ______________________________

5. PHYSICIAN INFORMATION

I certify that I am the physician/practitioner identified on this form, and I am prescribing a Wound Therapy System. I have reviewed the Detailed Written Order. Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge. I certify that I am qualified, under CMS guidelines, to sign and prescribe medical equipment and supplies. I certify that the patient/caregiver is capable and has successfully completed or will be trained on the proper use of products prescribed on this Written Order. The products listed and physician notes and other supporting documentation will be provided to an authorized distributor upon request. I understand any falsification, omission or concealment of material fact may subject me to civil or criminal liability. By faxing this form I am acknowledging that the patient is aware that an authorized distributor may contact them for any additional information to process this order. A copy of this order will be retained as part of the patient's medical record.

Physician's Name (Please Print) ____________________________NPI# ____________________

Physician's Address____________________________Physician's Phone ____________________

City ________________________State____________________Zip________________

Physician's Signature ______________________________ Date____________________

(Handwritten Signature Only; Signature and Dated Stamps Cannot Be Accepted)

For additional information call 1(866) 484-6798

This is a confidential message. It is intended solely for the person to whom it is addressed. It must be kept in strict confidence. If you receive this message in error, please forward it by fax to 1 (877) 832-6837.