Clear Form Print Form

ROTECH HEALTHCARE INC.

NEGATIVE PRESSURE WOUND THERAPY – FAX COVER

Please Send Both Pages to Rotech's NPWT Department:

FAX • 866-233-7102 EMAIL • npwt@rotech.com CUSTOMER SERVICE • 844-592-5068

PATIENT DELIVERY INFORMATION

Requested Delivery Date: _____ Requested Delivery Time: _____

Patient Name: _____ Patient DOB: _____

Address: _____ City/State/ZIP: _____

Patient Cell Phone: _____

Hospital Delivery: ☐ Deliver to Hospital ☐ Utilizing Consignment Pump – No Delivery Needed

Hospital/Facility Name: _____

Room Number: _____ Direct Phone Number to Patient's Room: _____

Anticipated Hospital/Facility Discharge Date: (if applicable)* _____

* *Medicare allows delivery to a hospital/facility up to 48 hours prior to anticipated discharge for the purpose of fitting and training.*

Home Delivery: Deliver to Patient's Home? ☐ Yes ☐ No ☐ Same Address as Listed on Form

OR

☐ Deliver to Alternate Address

Alternate Address: _____ City/State/ZIP: _____

PATIENT FOLLOW-UP CARE

Name of Home Health Agency Following the Patient: _____

Phone: _____ Fax: _____

Name of Wound Care Clinic Following the Patient: (if applicable) _____

Phone: _____ Fax: _____

REQUIRED DOCUMENTATION CHECKLIST

PLEASE ATTACH THE FOLLOWING:

☐ Face Sheet
☐ Pre-Op Report
☐ Current Wound Notes
☐ Physician Face-to-Face Notes
☐ Post-Op Report
☐ Prior Treatments *(if chronic wound)*

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ROTECH® HEALTHCARE INC.

NEGATIVE PRESSURE WOUND THERAPY – ORDER FORM

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PATIENT INFORMATION

Name: _____ DOB: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Mobile: _____ Email: _____

Insurance Provider: _____ Insurance ID#: _____

Secondary Insurance: _____ Insurance ID#: _____

STANDARD ORDER FOR NPWT *(Please Carefully Read and Check the Boxes Below…)*

I prescribe Negative Pressure Wound Therapy for: ☐ Pressure Ulcer(s) ☐ Venous Ulcer(s) ☐ Arterial Ulcer(s) ☐ Diabetic Ulcer(s) ☐ Surgically Created Wound(s) ☐ Disruption of the Wound (Unspecified) ☐ Other _____

I also prescribe a NPWT Pump, and up to 15 Wound Care Sets/Dressing Kits per wound per month and 10 Canister Sets per month.

- ► **Number of Months:** ☐ 1 Month ☐ 2 Months ☐ 3 Months ☐ 4 Months ☐ Other _____
- ► **Pressure Setting:** ☐ 100 ☐ 120 ☐ 140 ☐ Other _____
- ► **Change Dressings:** ☐ 3 times per week ***OR*** ☐ Other _____

Alternative Order: (ONLY fill out this section if an alternative to the standard order above is needed.)

☐ I prescribe the Negative Pressure Wound Therapy Pump and up to _____ Dressing Kits (quantity) per wound per month, and _____ Canister Sets (quantity) per month.

SUPPLIES FOR DELIVERY

(Please check ONE box for Foam or Gauze, and check ONE box for Size)

Dressing Kit: ☐ Foam ☐ Gauze **Size:** ☐ Small ☐ Medium ☐ Large ☐ **Other Supplies:** _____

(Y-Connectors, Gauze Rolls, etc.)

CURRENT WOUND MEASUREMENTS

Wound Location: *(Please attach additional information if more than one wound present)*

#1: _____ Age: _____ Measurement Date: _____ Necrotic tissue present? ☐ YES ☐ NO

Length: _____ Width: _____ Depth: _____

Tunneling: ☐ YES ☐ NO Location: From _____ o'clock to _____ o'clock

Undermining: ☐ YES ☐ NO Location: From _____ o'clock to _____ o'clock

Wound History: Was NPWT initiated in an inpatient facility? ☐ YES ☐ NO Date: _____

Is there anything compromising the patient's nutritional status? ☐ YES* ☐ NO **If YES, what measures have been taken?*

_____

Is the patient on a comprehensive diabetic management program? ☐ YES ☐ NO ☐ N/A

Is NPWT being ordered for any type of chronic wound (>30days or more)? ☐ YES* ☐ NO

**If YES, which previous wound treatments have been applied to maintain a moist wound environment to promote healing?*

_____

For Stage 3 & 4 Pressure Ulcers: Is the patient using a group 2 or 3 support surface? ☐ YES ☐ NO

Is patient on a turning schedule? ☐ YES ☐ NO Is moisture and incontinence being managed? ☐ YES ☐ NO

For Diabetic and or Neuropathic Ulcers: Is pressure on the foot being reduced with proper modalities? ☐ YES ☐ NO ☐ N/A

By signing and dating, I attest that I am prescribing Negative Pressure Wound Therapy as medically necessary and all other applicable treatments have been tried or considered and ruled out. I have read and understand all safety information and other instructions for use included with therapy clinical guidelines. Additionally, I have reviewed the information provided in this form and attest to its accuracy.

REFERRAL NAME: _____ **REFERRAL LOCATION:** _____

PHONE: _____ **FAX:** _____

ADDRESS: _____ **CITY/ST/ZIP:** _____

ORDERING PHYSICIAN NAME: _____ **NPI#:** _____

PHYSICIAN SIGNATURE: _____ **DATE:** _____