

AE Name: _____

AE ID#: _____

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)

AE Name: _____

AE ID#: _____

PATIENT INFORMATION

Name: _____ DOB: _____
Address: _____ City/State/Zip: _____
Home Phone: _____ Mobile: _____ Email: _____
Insurance Provider: _____ Insurance ID#: _____
Secondary Insurance: _____ Insurance ID#: _____
Requested Delivery Date: _____

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: _____
► Change Dressings: ☐ 3 times per week OR ☐ Other _____

SUPPLIES FOR DELIVERY

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

Renasys GO: ☐ Foam ☐ Gauze Size: ☐ S ☐ M ☐ L ☐ Other Supplies: _____
Genadyne XLR8+: ☐ Foam ☐ White Foam ☐ Gauze Size: ☐ S ☐ M ☐ L ☐ 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: _____