800-540-7252

Negative Pressure Wound Therapy

DATE____/____/________

CMN/Physician Order/Prescription

FAX THIS FORM & CLINICALS TO: 888-651-6709

Patient Information

Patient Name: Date of Birth: Gender M / F

Phone: Alternate Contact: Alternate Phone #:

Address: City: State: Zip Code:

Insurance Name & ID #: Group # Social Security #:

Medicaid State & ID #: Secondary Insurance:

PATIENT'S WOUND HISTORY

1. Will the NPWT be used in a ❒ Nursing Home/ Rehab ❒ Private Resident ❒ LTAC ❒ ALF ❒ Other ____________________
   Name of Facility: ________________________________ Phone:______________________ Date NPWT was initiated: __/__/__
2. Is there anything compromising the patient's nutritional status? ❒ Yes ❒ No
   If yes, what measures have been taken? ❒ Protein Supplements ❒ Enteral/NG Feeding ❒ TPN ❒Vitamin Therapy ❒Other _________
3. Is the patient's wound a direct result of an accident? ❒ Yes ❒ No Date of accident: __/__/__
   Accident Type: ❒ Auto ❒ Employment ❒ Trauma ❒ Responsible Party: ____

ADDITIONAL INFORMATION BY WOUND TYPE (**CHECK ONLY ONE)**

a. ❒ **Pressure Ulcer: ❒ Stage III ❒ Stage IV**
   Is moisture/incontinence being managed? ❒ Yes ❒ No ❒ N/A
   Was Group 2 or 3 support surface used for ulcers on the posterior pelvis or trunk prior to and during NPWT? ❒ Yes ❒ No ❒ N/A
   Is the patient being turned and positioned? ❒ Yes ❒ No ❒ N/A

b. ❒ **Diabetic and/or Neuropathic Ulcer/ Arterial Ulcer or Arterial insufficiency**
   Is the patient on a comprehensive diabetic management program? ˜ Yes ˜ No ˜ N/A
   Is pressure over wound being relieved? ❒ Yes ❒ No ❒ N/A

c. ❒ **Venous Insufficiency/ Venous Stasis**
   Are compression bandages and/or garments being consistently applied? ❒ Yes ❒ No ❒ N/A
   Is elevation/ambulation being encouraged? ❒ Yes ❒ No ❒ N/A

d. ❒ **Chronic Ulcer of Mixed or Unknown Etiology**
   Thick callus surrounding wound must be debrided prior to NPWT. Was it? ❒ Yes ❒ No ❒ N/A
   Wound must be present for more than 30 days. Was it? ❒ Yes ❒ No
   List previous treatments applied to maintain a moist wound environment without wound responding: ˜ Saline Soaked Gauze ˜
   Hydrocolloid ___ Alginate ____Hydrogel ____Absorptive ˜ Other ______________________________________

e. ˜ **Traumatic: Describe**______________________________ **Surgical: ˜ Dehisced ˜ Non-Dehisced**

WOUND MEASUREMENTS

Wound #1 Type: _______________ Wound Age (mos):____________
Is there less than 20% slough/fibrin in the wound? ___Yes ___No
Was wound debrided recently? ___Yes ___No
If yes, date: ______________________
Are serial debridements required? ___Yes ___No
Is muscle, tendon or bone exposed? ___Yes ___No
Does wound has MRSA? ___Yes ___No

Measurement date: __________Wound Location: _________.
Length: ________cm Width:__________ cm Depth: _______cm
Is there undermining? ___Yes ___No
Location #1: __________cm, from ______ to____________ o'clock
Location #2: __________cm, from ______ to____________ o'clock
Is there tunneling/sinus? ___Yes ___No
Location #1: __________cm, at _______ o'clock

EQUIPMENT/SUPPLIES PRESCRIBED

Products Ordred: (1) Extricare NPWT Device E2402,
(15) Each Dressings A6550, (10) Each Canisters A7000
Setting to be placed at:_________ MMHG, ❒Foam ❒Gauze.

DIAGNOSIS/LENGTH OF NEED

EST. LENGTH OF NEED (# OF MONTHS): ______ 1-99(99=lifetime)
DIAGNOSIS CODE/DESC(ICD): ___________________
DIAGNOSIS CODE/DESC (ICD): ___________________

Physician Information

Physician's Name: ______________________ Phone #: ______________________ Fax #: ______________________

Address: ______________________ City: ______________________ State: ________ Zip: ____________

UPIN #: ____________ NPI #: ____________ License #: ______________________ Exp Date: ______/______/______ (MM DD YY)

Physician's Signature ____ **Date** ______/______/______ (MM DD YY)

By my signature above, I confirm that the patient has the medical condition(s) listed and is being treated by me. All the information contained on this Physician's Order accurately reflects the patient's medical condition(s) and the treatment regimen that I have prescribed. The medical records for this patient substantiate the prescribed treatment plan. The patient/caregiver is able to use the prescribed product(s) listed above. My office has informed the patient that this order has been submitted to a DME supplier on behalf of the patient. For Medicare, Medicaid or other insurance requirements, I will maintain this signed original document in the patient's medical record file for post-payment review/audit purposes.