Prescription Form for Negative Pressure Wound Therapy

SECTION I: Prescription for Negative Pressure Wound Therapy *(print legibly)*

A. Prescriber Attestation *(Section 1A to be completed by prescriber only)*

Patient Name: ***(Last)***	***(First)***	***(Middle Initial)***
Address:	**City**	**State:** **Zip:**

I prescribe a negative pressure wound therapy system and up to 15 dressings per wound and up to 10 canisters per month for _______ months, starting on _____ /_____ /20____ for the following diagnosis:

ICD-10 Code (required): (1) (2) (3) (4) (5)

Prescription Indication: ***(mark one X)***

□ Secondary Closure *(promote granulation)* □ Tertiary Closure *(delayed primary)* □ Flap/Graft Preparation

****** The prescriber must sign and date the prescription prior to delivery of the negative pressure wound therapy system in accordance with CMS policy.******

Prescriber Signature: *(no stamps please)* **Date:** *(no stamps please)*	**NPI:**

By my signature, I attest that negative pressure wound therapy is medically necessary and all other applicable treatments have been tried or considered and ruled out. Negative pressure wound therapy is contraindicated with malignancy in the wound, untreated osteomyelitis, non-enteric unexplored fistula and/or necrotic tissue with eschar present. I am not placing negative pressure wound therapy dressings over exposed blood vessels or organs.

B. Prescription Information *(print legibly)*

Delivery Address:	City:	State: Zip:

Patient's Date of Birth:	SSN:	Insurance Carrier:	Ins# / HICN:

Deliver to: *(mark one)* □ Residence □ Wound Care Center □ SNF/LTAC □ Hospital

Printed Prescriber Name: *(Last)*	*(First)*	
Prescriber Address:	City:	State: Zip:

Phone:	Fax:	NPI:

SECTION II: Wound Types and Supplies *(print legibly)*

A. Type of wound(s) covered by this prescription:

□ Pressure Ulcer (stage III or IV) □ Diabetic Ulcer □ Surgical □ Dehisced	□ Arterial Ulcer □ Venous Stasis Ulcer □ Trauma (orthopedic) □ Trauma (soft tissue)	□ Amputation - Diabetic □ Amputation - Traumatic □ Graft □ Flap	□ Necrotizing Fascitis □ Fistula, Enteric (explored) □ Burns (Partial thickness/2nd degree)

B. Negative Pressure Wound Therapy Mode

□ Black Foam □ White Foam □ AMD Gauze	Please select negative pressure setting: □ $-70 \leq -75$mmHg □ $-120 \leq -125$mmHg □ -150mmHg ~~~~~~ Select One: □ Continuous Mode □ Intermittent Mode Therapy *(5 min at prescribed pressure; 2 min at -25mmHg)*

SECTION III: Order Contact *(print legibly)*

Contact Name/Title:	Phone:	Fax:
Facility Name:		

Home Health Agency (if Any): ______________________________ **Contact Name:** ___________________ **Phone Number:** __________________

Please fax this completed form to (650) 931-8928

Clinical Form for Negative Pressure Wound Therapy

Patient Name: ***(Last)***	***(First)***	**SSN:**
Name of person completing form:	**Date:**	**Phone:**

Patient and Wound Information

Was Negative Pressure Wound Therapy Initiated in an inpatient facility? YES ____ NO____ *(IF YES, complete information below)*

Date Negative Pressure wound therapy was initiated in this facility / / 20
2. Is there anything compromising the patient's nutritional status? □ Yes □ No If yes, what measures have been taken?

3. Is the patient is Diabetic □ Yes □ No If Yes, are they on a comprehensive diabetic management program? □ Yes □ No
4. Is negative pressure wound therapy being ordered for any type of chronic wound (>30days)? □ Yes □ No
5. Which previous therapies/protocols have been applied to promote moist wound healing?

6. What were the initial wound measurements?

7. Date of last debridement? Type of debridement?

Wound Type Information

□ **Pressure Ulcers:** □ Stage III □ Stage IV Is the patient being turned and positioned? □ Yes □ No Is a specialized support surface being utilized for ulcers on the posterior trunk or pelvis? □ Yes □ No Is moisture incontinence being managed? □ Yes □ No □ NA	□ **Venous Stasis Ulcers:** Are compression bandages being consistently applied? □ Yes □ No Is leg elevation/ambulation being encouraged? □ Yes □ No
□ **Diabetic or Neuropathic Ulcers:** Is foot ulcer pressure being reduced? □ Yes □ No	□ **Chronic Ulcers:** Is pressure over the wound being relieved? □ Yes □ No Is moisture being controlled? □ Yes □ No
□ **Traumatic, Surgically Created or Dehisced Wounds:**	If you answered NO to any of the above questions, please explain:

Wound Measurement

Wound #1 Type:	**Wound #2** Type:
1. Has all eschar been removed from the wound □ Yes □ No 2. Is there less than 20% necrosis in the wound? □ Yes □ No	1. Has all eschar been removed from the wound □ Yes □ No 2. Is there less than 20% necrosis in the wound? □ Yes □ No
If 1 or 2 is NO are serial debridements required? □ Yes □ No	If 1 or 2 is NO are serial debridements required? □ Yes □ No
Wound age (months): Location:	Wound age (months): Location:
L_____cm W_____cm D_____cm	L_____cm W_____cm D_____cm
Sinus/Tunnel #1 cm @ o'clock Sinus/Tunnel #2 cm @ o'clock Sinus/Tunnel #3 cm @ o'clock Undermining #1 cm @ o'clock Undermining #2 cm @ o'clock	Sinus/Tunnel #1 cm @ o'clock Sinus/Tunnel #2 cm @ o'clock Sinus/Tunnel #3 cm @ o'clock Undermining #1 cm @ o'clock Undermining #2 cm @ o'clock

If wound length, width or depth information is non-applicable, please explain:

Form completed by: **Date:** **Initial delivery date:**

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