PRESCRIPTION FOR NEGATIVE PRESSURE WOUND THERAPY

Patient Name, Address, Telephone and HIC Number	Supplier Name, Address, Telephone and NPI Number
DOB:________________ Phone:________________ HIC:________________	Phone:________________ NPI:________________

DIAGNOSIS

Diagnosis Codes: (ICD-10 taken to the fifth digit) ____________ ____________ ____________ ____________ ____________

HCPCS Code: ❐ **E2402** – Negative pressure wound therapy electrical pump, stationary or portable supplies ❐ **A6550** – Wound care set, for negative pressure wound therapy electrical pump, includes all supplies and accessories ❐ **A7000** – Canister, disposable, used with suction pump

Frequency and Quantity Ordered: ❐ Dressing Kits 15/1 mo. ❐ Canister Set Kits 10/1 mo.

Initial Start Date:__________________________ **Estimated Length of Need (1-4 months):**________

❐ NPWT Kits: ❐ S ❐ M ❐ L ❐ Foam ❐ White Foam ❐ Gauze

PATIENT'S WOUND HISTORY (ADDITIONAL MEDICAL DOCUMENTATION MAY BE REQUESTED)

1. NPWT utilized in last 90 days? : ❐ Yes ❐ No ❐ Inpatient ❐ Outpatient

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 ❐ Special Diet ❐ Other: ________________

3. Does patient have diabetes? ❐ Yes ❐ No IF YES: Patient is on a comprehensive management plan ❐ Yes ❐ No

4. Is wound older than 90 days? ❐ Yes ❐ No IF YES: Was biopsy performed? ❐ Yes ❐ No IF YES: Is cancer present ❐ Yes ❐ No

5. List previous treatments applied to maintain a moist wound environment without wound responding: ❐ Saline Soaked Gauze ❐ Hydrocolloid ❐ Alginate ❐ Hydrogel ❐ Absorptive ❐ Other: ______________________________

6. Fistula present to organ or body cavity within vicinity of wound? ❐ Yes ❐ No IF YES: ❐ Enteric or ❐ Nonenteric

7. Is there osteomyelitis present in the wound? ❐ Yes ❐ No If YES, treated with: ________________

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 II or III support surface used for ulcers on the posterior pelvis or trunk prior to NPWT ❐ Yes ❐ No ❐ N/A
Is the patient being turned and positioned appropriately? ❐ Yes ❐ No

b. ❐ **Diabetic and/or Neuropathic Ulcer**
Has the pressure on the foot ulcer been reduced with appropriate modalities ❐ Yes ❐ No ❐ N/A

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

d. ❐ **Chronic Ulcer of Mixed or Unknown Etiology (present more than 30 days)**
Pressure over ulcer relieved? ❐ Yes ❐ No Moisture incontinence managed? ❐ Yes ❐ No

e. ❐ **Traumatic**

f. ❐ **Surgical/Dehisced**

WOUND MEASUREMENTS (COMPLETE A SEPARATE WOUND ASSESSMENT FOR EACH ADDITIONAL WOUND)

Wound Location:______________________ Wound age: (months)________ Measurement date:____/____/____

Is necrotic tissue with eschar present? ❐ Yes ❐ No (Please obtain measurements after debridement)

If YES: Type of debridement: ❐ Mechanical ❐ Chemical ❐ Sharp/Surgical: If Sharp/Surgical, Date____/____/____

Length:______cm Width_______cm Depth______cm ***If depth is less than or equal to 0.5 cm, please provide documentation whether underlying structures (such as bone, muscle, fascia) are exposed.

Is there undermining? ❐ Yes ❐No If YES, complete details below.

Locations #1: ________cm, from ________ to ________ o'clock Locations #2: ________cm, from ________ to ________ o'clock

Tunneling/Sinus: ❐ Yes ❐No If YES, complete details: Location #1_________cm @___________o'clock / Location #2 _____________cm @___________o'clock

Exudate Type: ❐ Serous ❐ Serosanginous ❐ Other______________ Exudate Amount: ❐ <100 ml/day ❐ >100 ml/day

PRACTITIONER INFORMATION

Physician Name: ____NPI:______________

Address: ______________________________ City: ____________________State: __________ Zip:____________

Phone: ____________________ Date of face-to-face visit prior to ordering DME item:________________

Pracitioner's Signature:____**Date:**________________

Sales Rep:

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