

# NEGATIVE PRESSURE WOUND THERAPY PUMP STANDARD WRITTEN ORDER



Please fax to: 800 787 4945

Patient Name, Address, Telephone & Insurance ID#:

( ) - Ins ID#: \_\_\_\_\_

Patient DOB: / / Sex: (M/F)

Refer to NPWT checklist for all required documentation.

Referral Name \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Requested Delivery Date: \_\_\_\_\_ Requested Delivery Time: \_\_\_\_\_ D/C Date (if applicable) \_\_\_\_\_

Hospital Delivery Yes No Hospital/Facility Name: \_\_\_\_\_ Room #: \_\_\_\_\_

Delivery to Patient's Home – Same address as listed above

OR

Delivery to Alternate Address Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_

Diagnosis Code(s) ICD-10: \_\_\_\_\_

Negative Pressure Wound Therapy Pump (E2402) and up to 15 Dressing Kits (A6550) per wound per month and 10 Canister Sets (A7000).

OR

Negative Pressure Wound Therapy Pump (E2402) and up to \_\_\_\_\_ (qty.) Dressing Kits (A6550) per wound per month, and \_\_\_\_\_ (qty.) Canister Sets (A7000) per month.

Pressure Setting: 80mmHg 100mmHg 120mmHg Other: \_\_\_\_\_

Length of Need: 1 Month 2 Months 3 Months 4 Months Other: \_\_\_\_\_

TYPE OF SUPPLIES: (Select one size & type of dressing)

Dressing Kit: Foam Gauze Size: Small Medium Large Frequency of Dressing Changes \_\_\_\_\_

Other Supplies: \_\_\_\_\_  
(Y-Connectors, Additional Drape, Gel Patch Adhesive, etc.)

CURRENT WOUND INFORMATION: (Please attach additional information if more than one wound present)

Wound #1 Type: \_\_\_\_\_ Age: \_\_\_\_\_ Wound Location: \_\_\_\_\_ Necrotic tissue present? Yes No

Measurement Date: \_\_\_\_\_ 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 Not Applicable

Is NPWT being ordered for any type of chronic wound? (Greater than 30 days or more) Yes\* No \*If yes, what previous wound treatments have been tried to maintain a moist wound environment to promote healing? \_\_\_\_\_

For Stage III & IV Pressure Ulcers: Is the patient using a Group II or III Support Surface? Yes No

Is the 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 Not Applicable

**PROVIDER CERTIFICATION:**

I, the patient's treating provider, certify the medical necessity of these items for this patient and maintain medical records reflecting the medical justification and care provided.

Provider's Signature : \_\_\_\_\_ Date: \_\_\_\_\_ NPI: \_\_\_\_\_

Provider's Name: \_\_\_\_\_ Telephone: \_\_\_\_\_