℞ WRITTEN ORDER AND MEDICAL JUSTIFICATION
NEGATIVE PRESSURE WOUND THERAPY PUMP

Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & HIC#:**
PROCARE HOME MEDICAL 4215 Credit Union Drive Anchorage, AK 99503 Phone: (907) 274-0770 Fax: (907) 274-0773 NSC#: 1267160001	( ) - **HIC#:.** **Patient DOB: / / Sex: (M/F)**

Please fax orders along with required documentation to **(907) 274-0773** or email to dme@procarehm.com. 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 INFOMRATION: *(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: _____