


NEGATIVE PRESSURE WOUND THERAPY PUMP STANDARD WRITTEN ORDER

Date of Last Visit: _____

 <p style="text-align: center;">Please fax to: Anchorage (907) 274-0773 Fairbanks (907) 458-8914 Soldotna (907) 260-3757 Wasilla (907) 357-7883 or email to: dme@procarehm.com</p>	<p>Patient Name, Address, Telephone & Insurance ID#:</p> <p>() - Ins ID#: _____</p> <p>Patient DOB: / / Sex: (M/F)</p>
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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

<p>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.</p>		
<p>Provider's Signature : _____</p>	<p>Date: _____</p>	<p>NPI: _____</p>
<p>Provider's Name: _____</p>	<p>Telephone: _____</p>	