NEGATIVE PRESSURE WOUND THERAPY PUMP STANDARD WRITTEN ORDER

PROCARE HOME MEDICAL

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

Patient Name, Address, Telephone & Insurance ID#:

( ) - Ins ID#:

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

Refer to NPWT coverage criteria sheet for all required documentation.

Order Date: _____ Date of Last Visit: _____ Requested Delivery Time: _____ DC Date (if applicable) _____

Diagnosis Code(s) ICD-10: _____

Length of Need: ☐ 1 Month ☐ 2 Months ☐ 3 Months ☐ 4 Months ☐ Other: _____

☐ 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: _____

Equipment:

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

Pressure Setting: ☐ 80mmHg ☐ 100mmHg ☐ 120mmHg ☐ Other: _____

Supplies: *(Select one size & type of dressing)*

Dressing Kit: ☐ Foam ☐ Gauze **Size:** ☐ Small ☐ Medium ☐ Large

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

Frequency of Dressing Changes: _____

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 #2 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

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: _____