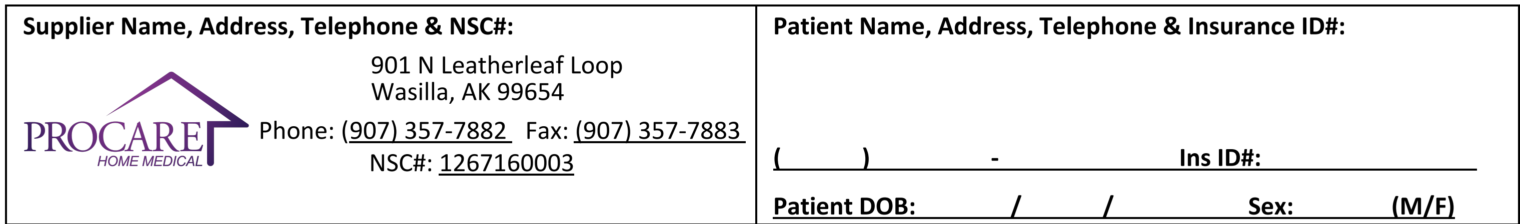
℞ WRITTEN ORDER AND MEDICAL JUSTIFICATION
NEGATIVE PRESSURE WOUND THERAPY PUMP



Supplier Name, Address, Telephone & NSC#:	**Patient Name, Address, Telephone & Insurance ID#:**
PROCARE HOME MEDICAL 901 N Leatherleaf Loop Wasilla, AK 99654 Phone: (907) 357-7882 Fax: (907) 357-7883 NSC#: 1267160003	**( ) - Ins ID#:** **Patient DOB: / / Sex: (M/F)**

Please fax orders along with required documentation to **(907) 3**57-7883 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: ______