Sales Reps complete this section.

Physicians only complete this section.

Negative Pressure Wound Therapy Order Form

CONFIDENCE FIRST MEDICAL SUPPLIES

Referred By:_____ **Fax : (310) 330-7635**

Physician's Full Name _____ NPI _____

Patient Name_____DOB_____Height/Weight_____

PRODUCTS

○ Negative Pressure Wound Therapy System

Location:

- ○ HOME
- ○ HOSPITAL
- ○ ASSISTED LIVING
- ○ SNF/LTAC
- ○ OUTPATIENT CLINIC

Dressing Type:

- ○ BLACK FOAM
- ○ WHITE FOAM

Pressure Relieving Products

- ○ Semi-electric hospital bed with Low Air Loss Mattress
- ○ Standard hospital bed with Low Air Loss Mattress
- ○ Wheelchair Cushion
- ○ Other:_____

Length of Need in Months: Circle one: 1 2 3 4 OTHER_____

THERAPY SETTINGS

○ **CONTINUOUS MODE** (40 mmHg – 200 mmHg)_____mmHg

○ **VARIABLE INTERMITTENT MODE**

Low Pressure (40-200) _____mmHg Cycle Time (1 minute increments) _____

High Pressure (40-200) _____mmHg Cycle Time (1 minute increments) _____

Notes_____

DIAGNOSIS (continues on pg. 2)

Wound Type: _____ **Diagnosis Code(s):**_____ **Stage** (if applicable)_____

Other Contributing Diagnoses: _____

CLINICAL INFORMATION

Y N n/a 1. Is the patient being seen regularly by a nurse, physician or other licensed practitioner?

Y N n/a 2. Has a care plan been established including ongoing nutritional assessments and consistent interventions?

Y N n/a 3. Is the moisture/incontinence being appropriately managed?

Y N n/a 4. Has the wound environment remained moist?

Y N n/a 5. While in the inpatient setting, was NPWT utilized on this wound?

Y N n/a 6. Has NPWT therapy ever been utilized prior? If Yes, date: _____

Physician Signature* _____

Signature Date & Order Date_____

By signing above I am authorizing the order of a Negative Pressure Wound Therapy System as medically necessary for the patient listed above. I am also proclaiming that all other applicable healing treatments have been attempted or considered and ruled out. I have read and understand all safety information and instructions for use included with this specific product as well as the systems it is contraindicated for: patients with malignancy of the wound, untreated osteomyelitis, non-enteric or unexplored fistulas, or necrotic tissue with the presence of eschar. Dressings for the Negative Pressure Wound Therapy system should never be placed directly in contact with exposed blood vessels, anastomotic sites, organs or nerves. I prescribe the Negative Pressure Wound Therapy system and up to 15 dressings per wound and 10 canisters per month.

*Physician Signature covers all sections on NPWT Order Form (page 1) and Statement of Ordering Physician (page 2).

Sales Reps

Physicians only complete this section.

NPWT Statement of Ordering Physician

CONFIDENCE FIRST MEDICAL SUPPLIES

Patient Name: _____ DOB: _____

WOUND INFORMATION

Wound Type: (Select Wound Type, then answer corresponding questions)

○ **Trauma** (check one): ❑ Orthopedic ❑ Soft Tissue/Open Wound ❑ Traumatic Amputation

○ **Surgical** **Date of Surgery:**_____

Y N 1. Have other post-operative wound healing techniques been attempted prior to ordering NPWT?

If "No", why is NPWT being ordered? _____

_____

○ **Pressure:** **Stage III** **or** **Stage IV** (circle one)

Y N 1. Has the patient been involved in a comprehensive ulcer treatment program?

Y N 2. Has the patient been on a Group 2 or 3 surface relieving the pressure on the trunk/pelvis?

If "No" why has it been ruled out? _____

_____

○ **Neuropathic & Diabetic**

Y N 1. Have prior pressure reducing techniques for the foot ulcer been attempted and failed?

○ **Venous Stasis**

Y N 1. Are compression garments being consistently applied to the wound?

Y N 2. Does the plan of care include elevation or ambulation of the extremities?

○ **Other: (i.e. Arterial, Burns)** _____

Description_____

_____

DIAGNOSIS (cont'd)

Wound #1 Description: _____

Location: _____

Length_____cm Width_____cm Depth_____cm

Undermining @_____o'clock _____cm

Tunneling @_____o'clock _____cm

Appearance of wound bed or odor: _____

_____

Amount of Exudate and Color: _____

1. Is there LESS THAN 20% eschar in the wound?

❑ Yes ❑ No

2. Has debridement been attempted in the last 10 days?

❑ Yes ❑ No

If Yes, date: _____

Wound #2 Description: _____

Location: _____

Length_____cm Width_____cm Depth_____cm

Undermining @_____o'clock _____cm

Tunneling @_____o'clock _____cm

Appearance of wound bed or odor: _____

_____

Amount of Exudate and Color: _____

1. Is there LESS THAN 20% eschar in the wound?

❑ Yes ❑ No

2. Has debridement been attempted in the last 10 days?

❑ Yes ❑ No

If Yes, date:_____

Please include most recent Chart Notes