

Patient Name: _____

Diagnosis: _____

Prescription for Negative Pressure Wound Therapy

- Indicate Pressure** _____ (60-80) mm Hg
- Dressing Change: Initial, then 48 hours, then** _____ x weekly
- Canisters:** Up to 10 per month
- Drain Type:** Channel Round Flat **Other:** _____
- Length of Therapy:** _____ (max. 3 months)

MD Signature, NPI Number & Date

NPWT pump and supplies will be denied if one or more of the following are present:

1. The presence in the wound of necrotic tissue with eschar, if debridement is not attempted. Yes No
2. Untreated osteomyelitis within the vicinity of the wound. Yes No
3. Cancer & / or presence of a fistula to an organ or body cavity within the vicinity of the wound? Yes No

STOP HERE IF ANY OF THE ABOVE ANSWERS ARE YES!!!

PATIENT'S WOUND INFORMATION- Criteria (The below information must be addressed prior to set up)

1. Documentation of evaluation, care, and wound measurements by a licensed medical professional. Yes No
2. Debridement of necrotic tissue if present. Yes No
3. Evaluation of and provision for adequate nutritional status Yes No **Dietitian Consult:** Yes No
4. Has the patient been on Negative Pressure Wound Therapy anytime during the last 60 days? Yes No Date: _____
5. Was NPWT initiated in an inpatient facility? Yes No Date initiated: _____ Name of facility: _____
6. Application of dressings to maintain a moist wound environment. Yes No
7. Which therapies have been applied before the use of negative pressure to maintain a moist wound environment?
(If none, need more documentation from MD as to why NPWT needed) _____
 Saline soaked gauze Hydrogel Alginate Hydrocolloid Absorptive other _____

Criterion

<input type="checkbox"/>	Pressure Ulcer: Stage III _____ Stage IV _____ Or Chronic Ulcer(s) of mixed etiology (being present for at least 30 days) including Arterial Insufficiency 1. The patient has been appropriately turned and positioned 2. The patient's moisture and incontinence had been appropriately managed. 3. Reduction of pressure over the wound is relieved 4. The patient has used a group 2 or 3 (ex. Low air loss mattress) support surface for ulcers on the posterior trunk or pelvis?	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes
<input type="checkbox"/>	Diabetic and/or Neuropathic 1. The patient has been on a comprehensive diabetic management program 2. Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities	<input type="checkbox"/> No <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Yes
<input type="checkbox"/>	Venous Insufficiency/Stasis 1. Compression bandages/garments have been being consistently applied 2. Leg elevation and ambulation have been encouraged	<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/>	Surgically created, traumatic or dehisced		

WOUND MEASUREMENTS

Wound #1 Type:	Location:	Wound age:	Wound #2 Type:	Location:	Wound age(mo):	
Measurement date:	Length:	Width:	Measurement date:	Length:	Width:	Depth:
Is there undermining? <input type="checkbox"/> Yes <input type="checkbox"/> No Location #1: _____ cm, from _____ to _____ o'clock Location #2: _____ cm from _____ to _____ o'clock			Is there undermining? <input type="checkbox"/> Yes <input type="checkbox"/> No Location #1: _____ cm, from _____ to _____ o'clock Location #2: _____ cm from _____ to _____ o'clock			
Is there tunneling/sinus? ? <input type="checkbox"/> Yes <input type="checkbox"/> No Location #1: _____ cm, from _____ to _____ o'clock Location #2: _____ cm from _____ to _____ o'clock			Is there tunneling/sinus? ? <input type="checkbox"/> Yes <input type="checkbox"/> No Location #1: _____ cm, from _____ to _____ o'clock Location #2: _____ cm from _____ to _____ o'clock			