

Patient Name: \_\_\_\_\_ DOB: / / \_\_\_\_\_ New Therapy Start Date: / / \_\_\_\_\_

Was NPWT utilized within the last 90 Days (anywhere)?

\*YES NO \*If Yes, Date Initiated: / / \_\_\_\_\_ \*If Yes, Facility Name: \_\_\_\_\_

Is the Patient's Nutritional Status Compromised?

\*YES NO \*If Yes, please attach nutrition plan. Albumin Level: \_\_\_\_\_ (If level is lower than 3.5, a Nutritional Consult is required by insurance)

Is Osteomyelitis present in the Wound? \*YES NO \*If Yes, treated with: \_\_\_\_\_

Which Therapies were utilized to maintain a moist wound environment?

Saline/Gauze  Hydrogel  Alginate  Hydrocolloid  Absorptive  Other: \_\_\_\_\_

Wound Location: \_\_\_\_\_ Wound Age: \_\_\_\_\_ Is the Wound Full Thickness? YES NO

Length: \_\_\_\_\_ cm Width: \_\_\_\_\_ cm Depth: \_\_\_\_\_ cm Measurement Date: / / \_\_\_\_\_

Exudate Amount: \_\_\_\_\_ Exudate Type: \_\_\_\_\_ Odor: YES NO

Please Circle what is Exposed: Muscle Tendon Bone None

Wound Bed Appearance: *"NPWT is contraindicated if any necrotic tissue is present"*

Is there eschar tissue present in the wound? \*YES NO Appearance of wound bed and color: \_\_\_\_\_

Is there Tunneling? \*YES NO Is there Undermining? \*YES NO
\*Location #1 cm, @ \_\_\_\_\_ o'clock \*Location #1 cm, From \_\_\_\_\_ to \_\_\_\_\_ o'clock
\*Location #2 cm, @ \_\_\_\_\_ o'clock \*Location #2 \_\_\_\_\_ cm, From \_\_\_\_\_ to \_\_\_\_\_ o'clock

Has a debridement been performed in the past 10 Days?

\*YES NO \*Debridement Date: / / \_\_\_\_\_ \*Debridement Type \_\_\_\_\_

Home Health Agency: \_\_\_\_\_ Phone #: \_\_\_\_\_

PHYSICIANS ORDER

I prescribe the ONPWT Pump @ - \_\_\_\_\_ mmHg (40-200mmHg)  Continuously  Intermittently

For the following Wound Type:  Surgical  Dehisced  Traumatic  Neuropathic/Diabetic Ulcer
 Venous/Arterial Ulcer  Pressure Ulcer  Other: \_\_\_\_\_

With an anticipated Length of Need of: \_\_\_\_\_ Months at 24 Hours per day (Medicare Allows 4 months with Wound Improvement).

I prescribe up to 15 dressing kits and up to 10 canisters per month. (Please select size/style)

Wound Location: \_\_\_\_\_ Therapy Start Date: / / \_\_\_\_\_

NPWT (q48-72hrs):  Small Foam  Med  Large Foam  White Foam
(check one)  Medium Gauze  Large Gauze  Silver dressing

NPWT Supplies (A Weekly): \_\_\_\_\_ Canisters \_\_\_\_\_ DY-Connector (For Multiple Wounds)

Goal of NPWT:  Assist Granulation Tissue Formation  Delayed Primary Closure  Flap/Graft

CD-10 Code: \_\_\_\_\_ Diagnosis: \_\_\_\_\_

Physician Name (Please Print): \_\_\_\_\_ NPI#: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_ Date: / / \_\_\_\_\_

By signing and dating, I attest that I am prescribing NPWT and supplies as medically necessary, and all other applicable treatments have been tried or considered and ruled out. I have read and understand all safety information and other instruction for use included with the NPWT product. I understand that NPWT is contraindicated for patients with: malignancy of the wound, untreated osteomyelitis, unmanaged malnutrition, non-enteric or unexplored fistulas necrotic tissue with eschar present and that NPWT dressings should not be placed over exposed vasculature, organs, nerves, anastomotic site of blood vessels or bypasses. The Durable Medical Equipment Medicare Administrative Contractors state coverage for NPWT will end if "any measurable degree of wound healing failed to occur over the prior month or "if four months have elapsed using an NPWT pump including time used in an inpatient setting. REV 11/2024