Smart Medical
PRODUCTS & SERVICES

Current PA Locations: Lancaster, Malvern, Philadelphia
Ph: 1-800-399-0250 Fax: 717-399-8128

WOUND THERAPY STATUS FORM

Complete this form in its entirety and MUST INCLUDE medical records, wound notes, etc. with the form. Fax form and documentation to 717-399-8128.

Patient Name: _____ Date of Birth: _____

Please answer the following questions:

When was the member last evaluated by a Physical or Wound Care Specialist?

_____

What type of wound is being treated?

☐ Stage III or IV pressure Ulcer ☐ Venous Ulcer ☐ Other
☐ Diabetic Ulcer ☐ Chronic Ulcer
☐ Arterial Ulcer ☐ Acute/Traumatic Ulcer

Location of Wound: _____

Date of Measurements: _____

Size Length (in cm): _____

Width: _____

Is tunneling present? ☐ Yes ☐ No

Amount of Drainage:

☐ None ☐ Small ☐ Moderate ☐ Large ☐ Copious

Type of Drainage:

☐ None ☐ Serosanguinous ☐ Bloody ☐ Yellow/Green
☐ Serous ☐ Purulent ☐ Tan ☐ Clear

Wound Bed (Select each applicable tissue type found in wound bed):

☐ Granulating ☐ Eschar ☐ Beefy Red ☐ White
☐ Sloughing ☐ Necrotic ☐ Pink

Is there an odor? ☐ Yes ☐ No

Quality of wound edges? ☐ Fused ☐ Detached

Is there undermining? ☐ Yes ☐ No

What is the duration of the wound?

☐ ≤ 14 days ☐ 15-30 days ☐ ≥ 30 days

How long has there been no evidence of wound healing?

☐ ≤ 7 days ☐ > 7 days

Smart Medical PRODUCTS & SERVICES

Current PA Locations: Lancaster, Malvern, Philadelphia

Ph: 1-800-399-0250 Fax: 717-399-8128

Has the wound been treated with a dressing that creates a moist environment for > 2 weeks without improvement? ☐ Yes ☐ No

Was the NPWT applied while the member was hospitalized? ☐ Yes ☐ No

Are weekly wound assessments being completed? ☐ Yes ☐ No

Who is monitoring woundvac therapy?

☐ Home Health Nurse ☐ Physician Office ☐ Wound Care Center ☐ Other

What is the member's mobility/ambulation status? _____

_____

Is the member's moisture and incontinence appropriately managed? ☐ Yes ☐ No

Is the member's current nutritional status being addressed to optimize wound healing? ☐ Yes ☐ No

What other treatments is the member currently receiving? (select all that apply)

☐ Diabetic management program
☐ Non-wt. bearing/pressure reduction interventions
☐ Compression/garment dressing
☐ Elevating extremity
☐ Group 2 or 3 support surfaces (i.e. powered mattress, air fluidized bed)
☐ Other

Please select all pre-existing systemic conditions that apply:

☐ Collagen Vascular Disease
☐ Diabetes mellitus
☐ Immune deficiencies
☐ Impaired nutrition
☐ Malignancy
☐ Peripheral Vascular Disease (PVD)
☐ Peripheral neuropathy
☐ Psychosis/depression
☐ None

Is the member currently receiving hospice services? ☐ Yes ☐ No

Additional Clinical Information: _____

_____

Reason for Item Request: _____

_____

FOR INITIAL WOUND VAC TREATMENT, OTHER WOUND TREATMENTS MUST HAVE BEEN TRIED AND FOUND INEFFECTIVE. IF OTHER TREATMENTS HAVE NOT BEEN TRIED, WOUND THERAPY WILL NOT BE COVERED. PLEASE SPECIFY BELOW THE ALTERNATIVE TREATMENT OPTIONS THAT WERE TRIED AND THE DURATION. IF NO OTHER TREATMENT OPTIONS WERE TRIED, PLEASE SPECIFY BELOW.

_____

_____

_____