HANDI MEDICAL SUPPLY

Negative Pressure Wound Therapy Order Form

Prescriber Information

Clinic/Location Name:
Prescriber Name:
Prescriber Address:
Prescriber City State Zip:
Prescriber Phone:
Prescriber Fax:
Prescriber NPI:

Patient Information

Patient Name:
Patient Address:
Patient City State Zip:
Phone:
DOB:
Primary Insurance:
Handi Customer Number:
Document ID#:

PRODUCTS

- ☐ Nisus NPWT Pump (E2402)
- ☐ Dressing Wound Kit, Medium (A6550) Qty per Month: _____ Freq. of Change: _____
- ☐ Dressing Wound Kit, Large (A6550) (Maximum of 15 dressing kits per wound, per month)
- ☐ Canisters, 250ml (A7000) Qty per Month: _____ Freq. of Change: _____
- ☐ Canisters, 500ml (A7000) (Maximum of 10 canisters per wound, per month)

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) _____

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 wound full thickness?
Y	N	n/a	4. Is the moisture/incontinence being appropriately managed?
Y	N	n/a	5. Has the wound environment remained moist?
Y	N	n/a	6. Is there 20% or less eschar in the wound?
Y	N	n/a	7. Has NPWT therapy ever been utilized prior? If **YES**, date: _____
Y	N	n/a	8. Has previous alternative treatment been tried prior to application of NPWT? If **YES**, what has been tried:

Order Date _____

Physician Signature _____ **Signature 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).

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Patient Name

DOB:
Document ID#:

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: _____
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: _____
Has debridement been attempted in the last 10 days?
☐ Yes ☐ No
If Yes, date:_____

Please include most recent Chart Notes

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