P: 888-573-1400
Complete entire form and fax to **330-665-4199**

Discharge Form

PATIENT INFORMATION	
Patient's Name (last, first, mi):	
Patient's DOB: ______/______/________ (mm dd yyyy)	Social Security #: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

PHYSICIAN'S GOAL FOR THERAPY:

Was the Physician's goal for therapy met? ☐ Yes ☐ No*

*If No, why not? ____

____

DISCHARGE ASSESSMENT [Indicate when Invia® Wound Therapy has been discontinued and the outcome.]

Therapy Discharge Date: ______/______/______ (mm dd yyyy)

Wound #1

Wound Location:

Wound Status [Check all that apply]

☐ Adequate granulation	☐ Patient in hospital	☐ Wound unresponsive	☐ Pain
☐ Wound healed	☐ Delayed primary closure	☐ Patient non-compliant	☐ Patient expired
☐ Wound sutured closed	☐ Tunnel dimensions decreased or closed	☐ Undermining improved or resolved	
☐ 4 months of treatment completed	☐ Other (please describe)		
Final wound measurements Date: ______/______/________ (mm dd yyyy)	Length: cm	Width: cm	Depth: cm

Wound #2 [Complete **only** if a second wound was treated.]

Wound Location:

Wound Status [Check all that apply]

☐ Adequate granulation	☐ Patient in hospital	☐ Wound unresponsive	☐ Pain
☐ Wound healed	☐ Delayed primary closure	☐ Patient non-compliant	☐ Patient expired
☐ Wound sutured closed	☐ Tunnel dimensions decreased or closed	☐ Undermining improved or resolved	
☐ 4 months of treatment completed	☐ Other (please describe)		
Final wound measurements Date: ______/______/________ (mm dd yyyy)	Length: cm	Width: cm	Depth: cm

Print name, title and employer of individual providing information:

Phone:	Date: ______/______/________ (mm dd yyyy)

Thank you for completing this form.

For DME Use Only:	Information taken verbally by ______________________ (DME employee) from ______________________ (caregiver) on ______/______/________ (mm dd yyyy) at ____________ (time)

V 4/2013