GALAXY Medical

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

Secondary Wound Assessment Form

Use this form for each additional wound requiring treatment with Invia® Wound Therapy.
Please include copies of all pertinent information from patient's medical record to validate the information provided here.

PRESCRIPTION, ATTESTATION & PRESCRIBER INFORMATION [Complete **ONLY** if patient is **ALREADY** undergoing treatment on Invia®.]

Patient Name [print] (last) _____ (first) _____ (mi) _____

Patient DOB: _____/_____/_____

I prescribe Invia® Wound Therapy. This includes: an Invia® Wound Therapy suction pump, up to 15 wound dressing kits/per Wound/per month and up to 10 canisters per month. The **anticipated length of therapy is _____ month(s)** to begin on or around _____/_____/_____ for the following diagnosis **(ICD-9-CM diagnosis code specific to 4th or 5th digit or narrative):**

★**Primary DX:** _____ Secondary DX:_____ Tertiary DX:_____★

Goal at the completion of Invia® Wound Therapy: ☐ **Assist Granulation Tissue Formation** ☐ **Delayed Primary Closure (Tertiary)**

☐ **Gauze Dressing OR** ☐ **Foam Dressing** is to be changed: _____ times per week with suction set at _____ **mmHg**

Prescriber's Signature: _____ **Date:** _____/_____/_____
(No stamps please)

Prescriber's Name **[print]** (last)	(first)	(mi)

Address:	City:	State:	Zip:

Phone:	Fax:	NPI:

WOUND TYPE & HISTORY [Check only one wound type below. Complete separate Secondary Wound Assessment Form for **each** additional wound.]

☐ **1. SURGICALY CREATED OR DEHISCED WOUND**

☐ **2. TRAUMATIC WOUND**

☐ **3. PRESSURE ULCER:** ☐ **Stage III** ☐ **Stage IV**
A) Is the patient being appropriately turned/positioned? ☐ Yes ☐ No
B) If patient's pressure ulcer is on the posterior trunk or pelvis, has a group 2 or 3 support surface been used? ☐ Yes ☐ No ☐ N/A
C) Is moisture/incontinence being managed? ☐ Yes ☐ No

☐ **4. VENOUS/ARTERIAL INSUFFICIENCY ULCER:**
A) Are compression bandages and/or garments being consistently applied? ☐ Yes ☐ No
B) Is leg elevation/ambulation being encouraged? ☐ Yes ☐ No

☐ **5. NEUROPATHIC ULCER (i.e., diabetic ulcer):**
A) Has pressure on the foot ulcer been reduced with appropriate Modalities? ☐ Yes ☐ No

☐ **6. CHRONIC ULCER/MIXED ETIOLOGY PRESENT AT LEAST 30 DAYS**
A) Is pressure over the wound being relieved? ☐ Yes ☐ No
B) Is moisture/incontinence being managed? ☐ Yes ☐ No

1) Which therapies have been previously utilized to maintain a moist wound environment? [Check all that apply.]
☐ Saline/Gauze ☐ Hydrogel ☐ Alginate ☐ Hydrocolloid ☐ Absorptive ☐ Other: _____
2) Is there Osteomyelitis present in the wound? ☐ No ☐ Yes ⇨ If Yes, treated with: _____
3) If wound is >90 days, has a biopsy been done? ☐ No ☐ Yes*
*If Yes, is cancer in the wound? ☐ No ☐ Yes ⇨ (contraindicated)
4) Is there a fistula to an organ or body cavity within vicinity of the wound? ☐ No ☐ Yes*
*If Yes: ☐ Enteric ☐ Non-enteric ⇨ (contraindicated)

WOUND MEASUREMENTS [Complete separate Secondary Wound Assessment Form for **each** additional wound.

Location of Wound:	**Wound Age in Months:**

Presence of necrotic tissue with eschar? ☐ No ☐ Yes* (Please obtain measurements after debridement.)
Date of last debridement: _____/_____/_____ **REQUIRED**
Type of Debridement:: ☐ Mechanical ☐ Chemical ☐ Surgical

Length: _____cm Width: _____cm Depth*: _____cm *If depth is less than or equal to 0.5 cm, please provide documentation whether underlying structures (such as bone, muscle, fascia) are exposed	Measurement Date: _____/_____/_____

Is there Undermining? ☐ No ☐ Yes* * If Yes, complete details below. Location #1: _____cm, from _____to _____ o'clock Location #2: _____cm, from _____to _____ o'clock	Is there tunneling/sinus? ☐ No ☐ Yes* *If Yes, complete details below. Location #1: _____cm, @ _____ o'clock Location #2: _____cm, @ _____ o'clock

Exudate Type: ☐ Serous ☐ Serosanguinous ☐ Other: _____	Exudate Amount: ☐ < 100 ml/day ☐ > 100 ml/day