GALAXY Medical

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

Monthly Wound Assessment Form

★ **Please complete a separate Monthly Wound Assessment Form for EACH WOUND currently being treated with Invia® Wound Therapy. Please include copies of all pertinent information from patient's medical record to validate the information provided here.** ★

PATIENT INFORMATION

Patient's Name (last, first, mi):

Patient's DOB: ____/_____/_____ | Social Security #: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

1) Has the clinical care provider for this patient changed in the last 30 days? ☐ No ☐ Yes

If Yes, Name of Organization: Phone:

2) Has the patient been on Invia® Wound Therapy for less than 30 days? ☐ No ☐ Yes ⇨ If Yes,
Placement Date: ____/ ____/ _____ Placement measurements ⇨ Length: _____cm Width: _____cm Depth: _____cm

3) Was the patient admitted to a hospital or SNF within the last 30 days? ☐ No ☐ Yes
If Yes, date admitted: _____/_____/_____ Date discharged: _____/_____/_____
Name of facility: _____ Phone: _____
Was the patient using the NPWT pump during this inpatient stay? ☐ No ☐ Yes

4) Was NPWT suspended at any time during the last 30 days? ☐ No ☐ Yes
If Yes, date suspended: _____/_____/_____ Date restarted: _____/_____/_____

5) Is patient continuing treatment on NPWT? ☐ No ⇨ Discharge Form ☐ Yes ⇨ Continue below

WOUND STATUS [Complete this section at least 7 days prior to next treatment cycle.]

1) Date last seen by physician: _____/_____/_____ **REQUIRED**

2) Date of last debridement: _____/_____/_____ **REQUIRED**

Type of Debridement:: ☐ Mechanical ☐ Chemical ☐ Surgical

(Ensure measurements below are <u>after</u> most recent debridement.)

3) Wound Location: _____ Measurement Date: _____/_____/_____
Wound measurements 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.

a. Sinus/Tunnel #1: _____cm @ _____o'clock. Undermining #1: _____cm @ _____ to _____o'clock.

Sinus/Tunnel #2: _____cm @ _____o'clock. Undermining #2: _____cm @ _____ to _____o'clock.

b: Wound bed color ☐ beefy red ☐ pale pink ☐ gray
Granulation tissue ☐ increased ☐ no change
Wound odor ☐ decreased ☐ no change ☐ no odor ☐ new

Wound margins ☐ decreased ☐ no change ☐ increased
Exudate amount ☐ slight ☐ moderate ☐ heavy
Exudate color ☐ clear ☐ pink ☐ bloody
☐ other _____

4) Has the standard supply of 15 wound dressing sets per wound per month and 10 canisters per month been adequate for this patient?

☐ No ☐ Yes ⇨ If No, a Client Services Representative will contact you regarding this.

_____ _____
Licensed clinician printed name, title Phone

_____ _____/_____/_____ _____
Signature Date Fax

For DME Use Only: Information taken verbally by _____from _____ on _____/_____/_____ at _____