GALAXY Medical

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

NPWT Continuation Orders

TO BE COMPLETED BY PRESCRIBER	**PRESCRIPTION, ATTESTATION AND PRESCRIBER INFORMATION**

Patient Name [print] (last, first, mi) ____ 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 for an additional _______ month(s) for the following diagnosis:

ICD-9-CM diagnosis code specific to 4th or 5th digit or narrative):

★ Primary: _________________________ Secondary:_________________________ Tertiary:_________________________ ★

Goal at the completion of Invia® Wound Therapy: ☐ Assist granulation tissue formation ☐ Delayed primary closure (tertiary)

☐ **Gauze Dressings** **OR** ☐ **Foam Dressings** 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 STATUS – WOUND #1

[Complete for all wound types for continuation of NPWT]

1) Date last seen by Physician: ______/______/________
2) Date of last debridement? ______/______/________ ☐ Mechanical ☐ Chemical ☐ Surgical

(Ensure measurements below are after most recent debridement.)

2) 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 ______________________________

WOUND STATUS - WOUND #2

3) Date last seen by Physician: ______/______/________
4) Date of last debridement? ______/______/________ ☐ Mechanical ☐ Chemical ☐ Surgical

(Ensure measurements below are after most recent debridement.)

2) 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 ______________________________