Negative Pressure Wound Therapy Request Forms

NPWT Customer Service
Phone: 888-573-1400

Complete entire form and fax to **888-665-4199**

Contact Name: _____ Organization: _____

Direct Phone: _____ Fax: _____

SECTION 1: PATIENT INFORMATION			
Patient's Name: Last:	First:	MI:	◯ M ◯ F
Patient's DOB:	Social Security #:		Cell Phone:
Infectious Disease: ◯ No ◯ Yes	If Yes: What?		
Patient's Permanent Address:			
City:	State:	Zip:	Phone:
Emergency Contact:	Phone:	Relationship to Patient:	

SECTION 2: INSURANCE INFORMATION	
PRIMARY INSURANCE: ☐ Molina ☐ Medicare ☐ Meridian ☐ Other	Group #:
Insurance Name:	Policy/ID #:
SECONDARY INSURANCE: ☐ Molina ☐ Medicare ☐ Meridian ☐ Other	Group #:
Insurance Name:	Policy/ID #:

SECTION 3: OUTPATIENT CLINICAL CARE PROVIDER INFORMATION (Will be administering dressing changes)		
Name of Organization:		
Address:		
City:	State:	Zip:
Organization Phone:	Organization Fax:	

SECTION 4: DELIVERY INFORMATION			
Requested delivery date:	☐ Please deliver to patient's home (same address as above)		
☐ Alternate location: Name of Location:		Phone:	
Address:	City:	State:	Zip:

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Patient's Name: Last:	First:	MI:	DOB:

Please include copies of all pertinent information from patient's medical record to validate the information provided below.

SECTION 5: WOUND CLINICAL INFORMATION	Complete a separate Secondary Wound Assessment Form for each additional wound.	
☐ **1. SURGICAL WOUND (dehiscence) OR TRAUMATIC WOUND**	**A)** Is there a need for accelerated formation of granulation tissue? **B)** Is there a need for delayed primary closure?	☐ Yes ☐ No ☐ Yes ☐ No
☐ **2. PRESSURE ULCER:** ☐ **Stage III** ☐ **Stage IV**	**A)** Is the patient being appropriately turned/positioned? **B)** For posterior trunk or pelvis pressure ulcer has a group 2 or 3 support surface been used? Make:_____ Model: _____ **C)** Is moisture/incontinence being managed?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
☐ **3. VENOUS INSUFFICIENCY ULCER**	**A)** Are compression bandages and/or garments being consistently applied? **B)** Is leg elevation/ambulation being encouraged?	☐ Yes ☐ No ☐ Yes ☐ No
☐ **4. DIABETIC ULCER / NEUROPATHIC ULCER**	**A)** Is pressure on the foot ulcer being reduced with the appropriate modalities? **B)** Is the patient on a comprehensive diabetic management program?	☐ Yes ☐ No ☐ Yes ☐ No
☐ **5. CHRONIC ULCER OF MIXED ETIOLOGY**	Is pressure over the wound being relieved?	☐ Yes ☐ No

SECTION 6: WOUND HISTORY	
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 the patient's nutritional status compromised?	☐ No ☐ Yes If Yes, check the actions taken: ☐ Protein Supplements ☐ Enteral/NG Feeding ☐ TPN ☐ Vitamin Therapy ☐ Other: _____
3) Was NPWT utilized within the last 60 days?	☐ No ☐ Yes If Yes: ☐ Inpatient ☐ Outpatient If Yes, Date initiated: _____/_____/_____ Facility Name: _____
4) Does patient have diabetes?	☐ No ☐ Yes If Yes, is patient on a comprehensive diabetic management program? ☐ No ☐ Yes
5) Is there osteomyelitis present in the wound?	☐ No ☐ Yes If Yes, treated with: _____
6) Yes, is cancer in the wound?	☐ No ☐ Yes (contraindicated)
7) Is there a fistula to an organ or body cavity within vicinity of the wound?	☐ No ☐ Yes If Yes, ☐ Enteric ☐ Non-Enteric ⇨ (contraindicated)
8) Is necrotic tissue with eschar present in the wound?	☐ No ☐ Yes If Yes, has debridement been attempted? ☐ Yes ☐ No Date: _____/_____/_____ Type: ☐ Mechanical ☐ Chemical ☐ Surgical

Patient's Name: Last:	First:	MI:	DOB:

Please include copies of all pertinent information from patient's medical record to validate the information provided here.

SECTION 7: WOUND DESCRIPTION

Wound Location:	Wound Age in Months:
Measurement Date:	Length: _____cm Width: _____cm Depth:_____cm
Is there Undermining? ☐ Yes ☐ No Location #1: _____cm from _____ to _____o'clock Location #2: _____cm from _____ to _____o'clock	Is there Tunneling? ☐ Yes ☐ No Location #1: _____cm @ _____ o'clock Location #2: _____cm @ _____ o'clock

Exudate amount ☐ none ☐ scant ☐ small/minimal ☐ moderate ☐ heavy/copious

Exudate color ☐ serous ☐ sanguineous ☐ serosanguineous ☐ purulent

Is the wound full thickness? ☐ Yes ☐ No Is muscle, tendon or bone exposed? ☐ Yes ☐ No

SECTION 8: PRESCRIPTION, ATTESTATION AND PRESCRIBER INFORMATION. Please complete in full.

Patient's Name: Last:	First:	MI:	Patient's DOB:

I prescribe Invia® Wound Therapy for ☐ 1 month ☐ 2 months ☐ 3 months ☐ other _____ months (average length is 3 months) and up to 15 foam dressing kits and 10 canister sets per month per wound. Invia® Wound Therapy is to begin on or around: _____

for the following diagnosis (ICD10 CM Diagnosis Code Required):

Primary DX: _____ Secondary DX:_____ Tertiary DX:_____

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

Dressing is to be changed: _____ times per week with suction set at _____mmHg

Prescriber's Name: Last:	First:	MI:	
Address:	City:	State:	Zip:
Phone:	Fax:	NPI:	

To be completed by treating prescriber only. Original Signature Required. No stamps please.

Prescriber's Signature: _____ Date:

By signing and dating, I attest that I am prescribing Invia® Wound Therapy as medically necessary, and all other applicable treatments have been tried or considered. I have read and understand all safety information and other instructions for use included with the Invia® Wound Therapy clinical guidelines. I have also reviewed the information provided in this form and attest to its accuracy.

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