AFFINITY MEDICAL SUPPLY

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Negative Pressure Wound Therapy Form

Name of Person Completing Form _____ **Phone** _____ **Date** _____

Patient Name _____ **Social Security #** _____ **Birthdate** _____

Address _____ **City** _____ **State** _____ **Zip** _____

❑ **Male** ❑ **Female** **Phone#** _____ **Family Contact** _____ **Phone#** _____

Organization providing clinical care _____ **Phone#** _____

❑ **Medicare** ❑ **Medicaid** ❑ **Private Insurance** **HIC/ID#**_____ **Group #** _____

Secondary Insurance Provider _____ **Group #** _____

Patient and Wound Information

1) Did patient have negative pressure wound therapy in a hospital? ❑ Yes ❑ No If yes, what hospital? _____

2) What dressing applications have been used to maintain a moist wound environment? ❑ Absorptive ❑ Alginate
❑ Hydrogel ❑ Hydrocolloid ❑ Saline Soaked Gauze ❑ Other _____

3) Debridement of necrotic tissue? ❑ Yes ❑ No ❑ N/A

4) Does patient have compromised nutritional status? ❑ Yes ❑ No If yes, please choose all that apply:
❑ Enteral/NG Feeding ❑ Protein Supplements ❑ Special Diet ❑ TPN ❑ Vitamin Therapy ❑ Other _____

5) Was patient on NPWT in the last 2 months? ❑ Yes ❑ No If yes, where? _____

Wound Type Information

❑ **Pressure Ulcer** ❑ Stage III ❑ Stage IV
- Patient been appropriately turned and positioned? ❑ Yes ❑ No ❑ N/A
- Patient has used a Group 2 or 3 support surface for ulcers on the posterior trunk or pelvis? ❑ Yes ❑ No ❑ N/A
- Moisture and incontinence being managed? ❑ Yes ❑ No ❑ N/A

❑ **Neuropathic/Diabetic Ulcer**
- Patient is on a diabetic management program? ❑ Yes ❑ No ❑ N/A
- Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities? ❑ Yes ❑ No ❑ N/A

❑ **Venous insufficiency ulcers**
- Compression bandages and or garments have been consistently applied? ❑ Yes ❑ No
- Leg elevation and ambulation have been encouraged? ❑ Yes ❑ No

Wound Measurement Information *(Must be completed by licenced medical professional)*

Wound# ____, **Type:** _____, **Wound Age** _____
Location _____ Measurement Date _____
Length _____ Width _____ Depth _____
Exudate _____ml/day *Measure wound at deepest depth*
Tunneling? ❑ Yes ❑ No
If yes, *(length)* _____cm and *(position)* _____o'clock

Wound# ____, **Type:** _____, **Wound Age** _____
Location _____ Measurement Date _____
Length _____ Width _____ Depth _____
Exudate _____ml/day *Measure wound at deepest depth*
Tunneling? ❑ Yes ❑ No
If yes, *(length)* _____cm and *(position)* _____o'clock

Prescription

❑ I prescribed the, Versatile 1™ Wound Vacuum System, up to 15 dressing kits and 10 complete canister kits for _____ months for the above named patient.

Date _____ **DX:** _____

Clinician Name *(print)* _____ **Signature** _____

Contraindications for NPWT are presence of necrotic tissue with eschar, untreated osteomyelitis within the vicinity of the wound, cancer present in the wound, presence of a fistula to an organ or body cavity within the vicinity of the wound, and/or exposed vessel or organ.

Please complete and fax this form to Affinity Medical Supply 1-806-209-0111 or mail it to 909 Highway 62-82, Suite 8, Wolfforth, TX 79382 For more information contact us toll free at 1-877-878-6648.