HOME PARENTERAL SERVICES INC.
www.hpsoftheozarks.com

HPS Phone: 417-269-0650
Toll Free: 800-637-9201
Please fax completed form to: 417- 269-0692

NEGATIVE PRESSURE WOUND THERAPY REFERRAL ORDERFORM

PRESCRIBER INFORMATION AND PRESCRIPTION (May be completed by a member of the Prescriber's Staff)

Patient Name: ***(print)*** _____, _____ _____/_____/_____
Last Name ***First Name*** ***DOB***

I prescribe Medela/Invia® Wound Therapy. This includes a Medela/Invia® Wound Therapy suction pump, up to 15 wound dressings sets/per wound/per month and up to 10 canisters per month. Anticipated length of therapy: _____ month(s) starting on _____/_____/_____

For the following diagnosis: (ICD-10-CM diagnosis code): _____

_____

Apply Medela/Invia® NPWT to _____ wound with vacuum set at _____mmHg, change dressing _____ times weekly.

Goal at the completion of Medela/Invia® Wound Therapy:

❑ Assist granulation tissue formation ❑ Delayed primary closure (tertiary) ❑ Flap ❑ Graft

PRESCRIBER SIGNATURE (NOTE: MUST BE PRESCRIBER ONLY ORIGINAL SIGNATURE ~~ NO STAMPS)

PRESCRIBER SIGNATURE:_____ ***Date*****:** _____ / _____ / _____

PRINTED PRESCRIBER NAME:_____

By signing and dating, I attest that I am prescribing Medela/Invia® Wound Therapy as medically necessary, and all other applicable treatments have been tried or considered and ruled out. I have read and understand all safety information and other instructions for use included with the Medela/Invia® Wound Therapy product, as well as Medela/Invia® Wound Therapy Clinical Guidelines. I also understand the Medela/Invia® Wound Therapy contraindications: Patients with malignancy in the wound, untreated osteomyelitis, non-enteric and unexplored fistulas, or necrotic tissue with eschar present. Avance Form dressing for the Medela/Invia® Wound Therapy should not be placed directly in contact with exposed blood vessels, anastomotic sites, organs, or nerves. The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) state that beyond the first four months of therapy, "to justify the need for each additional month of coverage, a new prescription for each month is required," in addition to supporting medical records that document medical need.

SUPPLIES REQUESTED:

Dressing Kit ❑ small ❑ medium ❑ large ❑ Canister ❑ Tubing ❑ Normal Saline 0.9% to cleanse wound ❑ Y-Connectors

Organization/Facility Providing Patient's Wound Care: _____

Medela/Invia® Wound Therapy will be used in what type of setting ❑ Private Residence ❑ Assisted Living ❑ WCC
Please contact HPS if in: ❑ Skilled Nursing Facility ❑ Rehabilitation Center ❑ Acute Care Facility ❑ LTACH

Delivery Address: _____, _____, _____, _____
City ***State*** ***Zip***

If a facility, Name: _____

Delivery Contact: _____ **Direct Phone:** ___ / _____ / _____

Name of person completing the order form:

Contact Name: _____ **Title:** _____ **Phone:** _____/_____/_____ **Fax: :** _____/_____/_____

Patient Name:_____ **DOB**:_____ **Date:**_____

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

(Check only one wound type below. Complete a separate Secondary Wound Assessment Form for each additional wound.)

❑ 1. SURGICALLY CREATED OR DEHISCED WOUND Date of Surgical Procedure: _____ / _____ / _____Description of Procedure: _____	
❑ 2. TRAUMATIC WOUND	
❑ 3. PRESSURE ULCER: ❑ Stage III ❑ Stage IV →	A) Is 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 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 (e.g., 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

WOUND HISTORY

1. Previously utilized therapies 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? ❑ Yes ❑ No→ If Yes, check the actions taken:
   ❑ Protein Supplements ❑ Enteral/NG Feeding ❑ TPN ❑ Vitamin Therapy ❑ Other: _____
3. Was NPWT utilized within the last 90 days? ❑ Yes ❑ No → If Yes: ❑ Inpatient ❑ Outpatient
   If Yes, Date initiated: _____ / _____ / _____Facility Name: _____
4. Does patient have diabetes: ❑ Yes ❑ No → If Yes, is patient on a comprehensive diabetic management program? ❑ Yes ❑ No
5. Is there osteomyelitis present in the wound? ❑ Yes ❑ No → If Yes, treated with: _____
6. If wound is >90 days, has a biopsy been done? ❑ Yes ❑ No If Yes, is cancer in the wound? ❑ Yes ❑ No→ (contraindicated)
7. Is there a fistula to an organ or body cavity within vicinity of the wound? ❑ Yes ❑ No→ If Yes: ❑ Enteric ❑ Non-enteric→ (contraindicated)

Additional medical documentation may be requested.

WOUND(S) DESCRIPTION

Wound #1 Type: _____ Age in Months: ____	**Wound #2 Type**: _____Age in Months: ____
Wound Location: _____	Wound Location: _____
Is there eschar tissue present in the wound? ❑Yes ❑No	Is there eschar tissue present in the wound? ❑Yes ❑No
Has debridement been attempted in the last 10 days? ❑Yes ❑No	Has debridement been attempted in the last 10 days? ❑Yes ❑No
If Yes, debridement date: _____ / _____ / _____	If Yes, debridement date: _____ / _____ / _____
Debridement type: _____	Debridement type: _____
Are serial debridements required? ❑Yes ❑No	Are serial debridements required? ❑Yes ❑No
Measurement date: _____ / _____ / _____	Measurement date: _____ / _____ / _____
Length: _____cm Width: _____cm Depth: _____cm	Length: _____cm Width: _____cm Depth: _____cm
Wound bed appearance and color: _____	Wound bed appearance and color: _____
Is the wound full thickness? ❑Yes ❑No	Is the wound full thickness? ❑Yes ❑No
Exudate (amount and color): _____	Exudate (amount and color): _____
Is there undermining? ❑Yes ❑No	Is there undermining: ❑Yes ❑No
Location #1_____cm, from_____ to_____ o'clock	Location #1_____cm, from_____ to _____ o'clock
Location #2_____cm, from_____ to _____ o'clock	Location #2_____cm, from_____ to _____ o'clock
Is there tunneling/sinus? ❑Yes ❑No	Is there tunneling/sinus? ❑Yes ❑No
Location #1_____cm, from_____ to _____ o'clock	Location #1_____cm, from_____ to _____ o'clock
Location #2_____cm, from_____ to _____ o'clock	Location #2_____cm, from_____ to _____ o'clock
Is muscle, tendon or bone exposed? ❑Yes ❑No	Is muscle, tendon or bone exposed? ❑Yes ❑No

Signature of Person Completing Form:_____