NPWT System Prescription Form

Please Note: This is a preliminary eligibility form; Supporting Medical Records will be required upon approval.

info@custommedicalsolutions.com | www.custommedicalsolutions.com

* Required Fields

(Contact person for this form)

From: * | Title:

Facility Name: * | Phone: | Fax:

1. Complete the patient's name and delivery information

Patient's Name: * | Patient's Address: *

City: * | State: * | Zip: * | Phone: *

Family Contact: | Delivery Address: *

City: * | State: * | Zip: * | Phone: *

The NPWT System will be used in what type of facility *

- [ ] Home
- [ ] LTAC
- [ ] Rehab
- [ ] Assist. Living
- [ ] Group Home
- [ ] Other

2. Check the primary wound type covered by this prescription, even if debrided *

- [ ] Amputation-Diabetic
- [ ] Amputation-Traumatic
- [ ] Arterial Ulcer (Insufficiency)
- [ ] Burns (Partial Thickness / 2)
- [ ] Diabetic Ulcer
- [ ] Dehisced (Disrupted)
- [ ] Fistula, Enteric *
- [ ] Flap (Post-op)
- [ ] Graft (Post-op)
- [ ] Stage III Pressure Ulcer
- [ ] Stage IV Pressure Ulcer
- [ ] Surgical (Non-Dehisced)
- [ ] Trauma (Orthopedic)
- [ ] Trauma (Soft Tissue / Open Wounds)
- [ ] Venous Stasis Ulcer

** Not Currently Covered by Medicare*

3. Complete only if you will not be faxing this information separately (Patient's Face Sheet)

Patient's DOB: * | SS#: *

Primary Insurance: * [ ] Medicare [ ] Private Insurance

HIC#: * | Private Insurance Name: *

Private Insurance Address: *

Policy#: * | Group Name:

Secondary Insurance: [ ] Medicare [ ] Private Insurance

HIC#: | Private Insurance Name:

Private Insurance Address:

Policy#: | Group Name:

4. Check the NPWT Dressing Set Requested

Dressing Set: ☐ Small ☐ Medium ☐ Large

Additional Supplies: ☐ White Foam ☐ "Y" Connect

Canister: ☐ 800cc Canister ☐ 300cc Canister

5. Complete the information regarding the organization that will be providing the patient's care

Name of Organization: * ______ Address: * ______

City: * ______ State: * ______ Zip: * ______ Phone: ______ Fax: ______

Contact Name: ______ Contact Phone: ______

Patient's Name: ______ SS#: ______

Contact Name: ______ Phone: ______

A. Patient's Wound History

1. Was NPWT initiated in an inpatient facility? * ◯ Yes ◯ No If Yes, Date Initiated: ______

   or has the patient been on NPWT any time during the last 60 days? * ◯ Yes ◯ No

2. Is the patient's Nutritional Status Compromised? * ◯ Yes ◯ No

   ☐ Protein Suppliments ☐ Enteral / NG Feeding ☐ TPN ☐ Vitamin Therapy ☐ Special Diet

3. Which therapies have been previously utilized to maintain a moist wound environment? *

   ☐ Saline / Gauze Hydroget ☐ Hydrocolloid ☐ Absorptive Other: ______

4. Is the patient on a comprehensive diabetic management program? * ◯ Yes ◯ No ◯ N/A

5. Is the patient's wound a direct result of an accident? * ◯ Yes ◯ No Date of Accicent: ______

B. Wound Measurements (Not to be completed by supplier)

Wound #1 Type: * ______

Wound Age in Months: * ______

Is there <20% slough / fibrin in the wound? * ◯ Yes ◯ No ◯ N/A

Are serial debridements required? * ◯ Yes ◯ No ◯ N/A

Measurement Date: * ______

Wound Location: * ______

Length: * ______ Width: * ______ Depth: * ______

Is there Undermining? * ◯ Yes ◯ No

Location #1: ______ cm, From ______ to ______ O'clock

Location #2: ______ cm, From ______ to ______ O'clock

Wound #2 Type: ______

Wound Age in Months: ______

Is there <20% slough / fibrin in the wound? ◯ Yes ◯ No ◯ N/A

Are serial debridements required? ◯ Yes ◯ No ◯ N/A

Measurement Date: ______

Wound Location: ______

Length: * ______ Width: * ______ Depth: * ______

Is there Undermining? ◯ Yes ◯ No

Location #1: ______ cm, From ______ to ______ O'clock

Location #2: ______ cm, From ______ to ______ O'clock

Wound #1:	Wound #2:
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

* If wound measurements do not apply (flap), explain: ____

C. Additional Information by Wound Type (choose one of the options in bold, and answer the corresponding questions) *

☐ Traumatic, Surgically Created or Dehisced Pressure Ulcer:

1. Is the patient being turned / positioned? ◯ Yes ◯ No
2. Has a group 2 or 3 surface been used for ulcer located on the posterior trunk or pelvis? ◯ Yes ◯ No
3. Are moisture and / or incontinence being managed? ◯ Yes ◯ No

☐ Diabetic and / or Neuropathic Ulcer : Is foot pressure being reduced? ◯ Yes ◯ No

☐ Venous Insufficiency:

1. Are compression bandages and / or garments being consistently applied? ◯ Yes ◯ No
2. Is elevation / ambulation being encouraged? ◯ Yes ◯ No

☐ Chronic ulcer of mixed or unknown etiology including arterial insufficiency:

1. Is pressure over the wound being relieved? ◯ Yes ◯ No
2. Is moisture / incontinence being controlled? ◯ Yes ◯ No

If "NO" please explain: ____

Prescription, attestation and prescriber information (Prescriber must sign and date. This form is only to be used when prescribing a NPWT System. DO NOT SUBSTITUTE.

Patient Name (Last): * ____ (First): * ____ (MI): * ____

I prescribe NPWT and up to 15 Dressing Sets per month and up to 10 Canisters per month

for ____ months, starting on ____

for the following diagnosis (ICD9 or narrative): ____

Prescriber's Signature: * ____ Date: * ____

By my signature, I attest that I am prescribing the NPWT. (DO NOT SUBSTITUTE) 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 NWPT products as well as the clinical guidelines. I authorize NPWT and up to 15 Dressing Sets per month and up to 10 Canisters per month for the period described above.

Prescriber's Name (Last): * ____ (First): * ____ (MI): ____

Address: ____ City: ____ ST: * ____ Zip: ____

Prescriber's Phone: * ____ Fax: ____ NPI: ____

Goal at the completion of NPWT: ☐ Assist Granulation Tissue Formation ☐ Flap ☐ Graft ☐ Delayed Primary Closure

Any changes that need to be made after submission - please fax to 877-381-6811

The PHI (Personal Health Information) contained in this prescription form is highly confidential. It is intended for the exclusive use of the addressee. It is to be used only to aid in providing specific healthcare services to this patient. Any other use is a violation of Federal Law (HIPAA) and will be reported as such. If the reader of this message is not the intended recipient, or the employer or agent responsible for delivering it to the intended recipient, you are hereby notified that any use, dissemination, distribution of this email is strictly prohibited. If you have received this e-mail in error, please notify the sender by calling 1-866-350-5640 and return the original message to the address listed above.