Instructions for Negative Pressure Wound Therapy (NPWT) Prescription and Clinical Information Form

Please use the instructions below to help you complete this form and expedite service. All information must be completed for the beneficiary to qualify for Medicare.

SECTIONS 1 & 2

PRESCRIPTION & PRESCRIBER INFORMATION

To be completed by the prescriber.

1. Only complete this prescription if you will not be providing a separate detailed written order.
2. Prescriber must **SIGN** and **DATE** the Prescription and Attestation. **No stamped signatures.**
3. Contact Tri-Care Home Medical for a Letter of Medical Necessity for Additional Supplies if the clinical condition of the wound requires more than 15 dressings per wound and/or 10 canisters per month.
4. Indicate what supplies you are requesting.

SECTIONS 3 & 4

PRODUCT DELIVERY AND PATIENT INFORMATION

1. Please provide information about who is requesting the Venturi Wound Therapy and where to deliver the equipment/supplies.
2. Indicate the anticipated placement date so we can ensure all supplies are delivered on time.
3. Provide us with all of the patient's demographic information along with all insurance information for proper billing and quick authorization.

SECTION 5

CLINICAL WOUND INFORMATION

1. Answer only the questions that relate to the patient's specific wound type. Only **one** wound type should be selected here.
2. Answer Questions 1-6, and **also fax (318-387-7682) all documentation from the patient's medical record substantiating this prescription including:**
   a) Wound history*
   b) Wound measurements
   c) Nutritional status
3. Record the wound measurements for each wound being treated with Venturi Healing System.
4. Complete a Supplemental Wound Profile Form if there is more than two wounds to be treated with negative pressure wound therapy.

* The above information may be contained in the patient's medical records, H&P, Operative Report or Nursing or Physician Progress Notes in the patient's chart.

WARNING: As with any prescription medical device, failure to consult a physician and follow all Instructions for Use prior to and during use, may lead to improper product performance and the potential for serious or fatal injury. For additional information, please see Talley's website at www.talleygroup.com.

To order, fax 318-387-7682 • Questions 318-387-0664 or 1-888-943-9695

Prescription and Clinical Information Form - Page 1

Prescriber must sign & date in Section 1 after reviewing the Prescription and Clinical Information pages. This form is only to be used when prescribing Negative Pressure Wound Therapy using the Venturi Healing System. DO NOT SUBSTITUTE.

Patient Name (print): _____ SS#: _____

Contact Name: _____ Phone: _____

1 PRESCRIPTION, ATTESTATION AND PRESCRIBER INFORMATION

Patient Name [print] (last) _____ (first) _____ (mi) _____

I prescribe the Venturi Healing System. This includes: the Venturi suction pump, up to 15 wound dressing sets/per wound/per month and up to 10 canisters per month. The anticipated length of therapy is _____ months starting on _____ for the following diagnosis (ICD-9-CM diagnosis code specific to 5th digit or narrative): _____

Prescriber's Signature _____ Date _____

By my signature, I attest that I am prescribing the Venturi Healing System 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 Venturi Healing System.

Prescriber Name [print] (last) _____ (first) _____ (mi) _____

Address _____ City _____ State _____ Zip _____

Prescriber Phone _____ Fax _____ NPI _____

Goal at the completion of therapy with Venturi Healing System:

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

2 SUPPLIES FOR DELIVERY

☐ Standard Flat	Flat Drain, Kerlix AMD gauze, 2 clear dressings; 20ml normal saline; Hydrogel adhesive patch; connection tubing with clamp; instructions for use
☐ Large Flat	Flat Drain, Kerlix AMD gauze, 2 clear dressings; 20ml normal saline; Hydrogel adhesive patch; connection tubing with clamp; instructions for use
☐ Standard Channel	Channel silicone drain, Kerlix AMD gauze, 2 clear dressings; 20ml normal saline; Hydrogel adhesive patch; connection tubing with clamp; instructions for use ***(used for tunneling, undermining, etc.)
☐ Abdominal	Flat drain, 2 Kerlix AMD gauzes, 4 clear dressings; 60ml normal saline; 3 Hydrogel adhesive patches; connection tubing with clamp; instructions for use
☐ Other Supplies	_____

3 REQUESTOR, CLINICAL PROVIDER, AND PRODUCT DELIVERY INFORMATION

Requestor's Name: _____ Requestor's Title: _____

Requestor's Facility Name: _____ Facility NPI: _____

Facility Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

Preferred Communication Method: ☐ Phone ☐ Fax ☐ Email _____

The Venturi System will be used in what type of facility: ☐ Private Residence ☐ SNF ☐ LTAC ☐ Rehab ☐ Assisted Living ☐ Group Home ☐ Custodial Care ☐ Other: _____

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Patient Name: _____

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3 CONT'D (Must be completed in full)

CLINICAL PROVIDER/FACILITY INFORMATION

☐ Requestor is same as Clinical Provider ☐ Clinical Provider not known at this time (please forward information as soon as possible)

Name of Clinical Provider Providing Dressing Changes: _____ Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

DELIVERY ADDRESS (Deliveries cannot be made to a P.O. Box)

☐ Deliver to Patient Home ☐ Deliver to Facility ☐ Other: _____

Delivery Address: ☐ Same as Patient Address ☐ Same as Requestor Address ☐ Other Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

Contact Name at this Address: _____ Title: _____

Location Where Therapy Administered: ☐ Same as Patient Address ☐ Other Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

If the patient should need additional supplies or services, what physical address should be used?

☐ Same as Patient Address ☐ Same as Requestor Address ☐ Other Address: _____

City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

Anticipated Placement Date: ____/____/____

4 Patient Information (Complete in Full or Fax Patient Face Sheet)

Patient's Permanent Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Family Contact: _____ Phone: _____

Is the patient's wound a direct result of an accident? ☐ Yes ☐ No Date of accident: ____/____/____

Accident Type: ☐ Auto ☐ Employment ☐ Trauma Responsible Party: _____

INSURANCE INFORMATION: COMPLETE ONLY if you will not be faxing this information separately (Patient Face Sheet).

Primary Insurance: ☐ Medicare ☐ Insurance ☐ Medicaid HIC/ID#: _____

Insurance Name: _____ Address: _____

Policy #: _____ Group Name: _____ Group #: _____

Primary Insured (Subscriber) Name: _____ Subscriber Relationship to Patient: _____

Subscriber DOB: _____ Insurance Phone: _____

Secondary Insurance: ☐ Medicare ☐ Insurance ☐ Medicaid HIC/ID#: _____

Insurance Name: _____ Address: _____

Policy #: _____ Group Name: _____ Group #: _____

Secondary Insured (Subscriber) Name: _____ Subscriber Relationship to Patient: _____

Subscriber DOB: _____ Insurance Phone: _____

5 Clinical Information by Wound Type (Complete in Full. Insurance Coverage may Require Additional Documentation)

PATIENT'S WOUND HISTORY

1. Was NPWT initiated in an inpatient facility? ☐ Yes ☐ No Date Initiated: _____
   OR has the patient been on NPWT anytime during the last 60 days? ☐ Yes ☐ No Facility Name: _____
2. Is the patient's nutritional status compromised? ☐ Yes ☐ No City, State: _____
   If yes, check the action taken: ☐ Protein Supplements ☐ Enteral/NG Feeding ☐ TPN ☐ Vitamin Therapy ☐ Special Diet

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Patient Name: _____

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3. Which therapies have been previously tried and failed to maintain a moist wound environment?
   ☐ Saline/Gauze ☐ Hydrogel ☐ Alginate ☐ Hydrocolloid ☐ Absorptive ☐ Other: _____
4. Is the patient a diabetic? ☐ Yes ☐ No
5. If other therapies were considered and ruled out, what conditions prevented you from using other therapies prior to applying NPWT with Venturi in inpatient or home health?:
   ☐ Presence of co-morbidities ☐ High risk of infection ☐ Need for accelerated granulation tissue
   ☐ Prior history of delayed wound healing ☐ Other, please describe: _____
6. Describe the co-morbidities or complicating factors which impair wound healing for this patient and possible consequences if Venturi is not used (complicating factors not impacting wound healing do not need to be provided):

_____

_____

_____

PATIENT'S PRIMARY WOUND TYPE

☐ **TRAUMATIC:** ☐ Orthopedic ☐ Soft Tissue/Open Wound ☐ Traumatic Amputation

☐ **SURGICAL:** ☐ Surgical (non-dehisced) ☐ Dehisced (disrupted) ☐ Flap (post-op) ☐ Graft (post-op) ☐ Necrotizing Fascitis
☐ Date of Surgery: ____/____/____ ☐ Other (please describe) _____

☐ **PRESSURE ULCER:** ☐ Stage III ☐ Stage IV (If No, please explain.)
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 _____
4. Is pressure ulcer greater than 30 days? ☐ Yes ☐ No _____

☐ **DIABETIC ULCER:**
1. Is the patient on a comprehensive diabetic management program? ☐ Yes ☐ No _____
2. Has a reduction of pressure on the foot ulcer been accomplished with appropriate modalities? ☐ Yes ☐ No _____

☐ **NEUROPATHIC ULCER:**
1. Has a reduction of pressure on the foot ulcer been accomplished with appropriate modalities? ☐ Yes ☐ No _____

☐ **VENOUS STASIS ULCER/VENOUS INSUFFICIENCY:**
1. Are compression bandages and/or garments being consistently applied? ☐ Yes ☐ No _____
2. Is elevation/ambulation being encouraged? ☐ Yes ☐ No _____

☐ **ARTERIAL ULCER/ARTERIAL INSUFFICIENCY:**
1. Is pressure over the wound being relieved? ☐ Yes ☐ No _____

☐ **BURNS** (Not currently covered by Medicare)

☐ **OTHER** (Explain) _____

WOUND MEASUREMENTS

Wound #1 Type: _____ Wound Age in Months: _____
Is there less than 20% slough/fibrin in the wound? ☐ Yes ☐ No
Has debridement been attempted in the last 10 days? ☐ Yes ☐ No
If Yes, debridement date: _____ Debridement type: _____
Are serial debridements required? ☐ Yes ☐ No
Measurement Date: _____ Wound Location: _____
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/sinus? ☐ Yes ☐ No
Location #1: _____ cm @ _____ o'clock
Location #2: _____ cm @ _____ o'clock
Appearance of wound bed and odor: _____
Exudate (amount and color): _____

Wound #2 Type: _____ Wound Age in Months: _____
Is there less than 20% slough/fibrin in the wound? ☐ Yes ☐ No
Has debridement been attempted in the last 10 days? ☐ Yes ☐ No
If Yes, debridement date: _____ Debridement type: _____
Are serial debridements required? ☐ Yes ☐ No
Measurement Date: _____ Wound Location: _____
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/sinus? ☐ Yes ☐ No
Location #1: _____ cm @ _____ o'clock
Location #2: _____ cm @ _____ o'clock
Appearance of wound bed and odor: _____
Exudate (amount and color): _____

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