The Venturi Healing System Discharge Form

TALLEY MEDICAL VENTURI™

SECTION 1. Patient Information (May be completed by the supplier, any clinician or staff.)

Patient Name: (last) _____ (first) _____ (mi) _____

SS#: _____

SECTION 2. Physician's Goal for Therapy

Was the physician's goal for therapy met? ☐ Yes ☐ No*

*If no, why not? _____

_____

SECTION 3. Discharge Assessment (Indicate why and when Venturi has been discontinued.)

Wound #1

Wound location:		**Therapy Discharge Date:** / /	
Wound Status (check appropriate box below):			
☐ Adequate granulation	☐ Patient in hospital	☐ Wound unresponsive	☐ Pain
☐ Wound healed	☐ Delayed primary closure	☐ Patient non-compliant	☐ Patient expired
☐ Wound sutured closed	☐ 4 months of treatment completed		
☐ Other (please describe)			
Final wound measurements Date: / /	Length: cm	Width: cm	Depth: cm

Wound #2

Wound location:		**Therapy Discharge Date:** / /	
Wound Status (check appropriate box below):			
☐ Adequate granulation	☐ Patient in hospital	☐ Wound unresponsive	☐ Pain
☐ Wound healed	☐ Delayed primary closure	☐ Patient non-compliant	☐ Patient expired
☐ Wound sutured closed	☐ 4 months of treatment completed		
☐ Other (please describe)			
Final wound measurements Date: / /	Length: cm	Width: cm	Depth: cm

Print name, title and employer of individual providing information:	
Phone #:	Date:

Please fax this completed form to 318-387-7682. Please file the original in the providers patient record.

Thank you for completing this form.

To order, fax 318-387-7682 • Questions 318-387-0664