PRESCRIPTION FORM
PATIENT DEMOGRAPHICS

Telephone: 516-333-2473
Fax:1-516-333-1669

NEGATIVE PRESSURE THERAPY

PRESCRIPTION FOR SMITH & NEPHEW NEGATIVE PRESSURE WOUND THERAPY

Patient Name(last) ______________________ (first) ________________ (mi)________

Patient Address ______________________ City ________________ State _____ Zip________

I prescribe Smith & Nephew Negative Pressure Wound Therapy(NPWT) Pump and up to 15 Therapy dressing sets and up to 10 Therapy Canister sets per month for _____ months, starting on ___/___/_____, for the following diagnosis (ICD-9 or narrative) ______________________. Set pressure at __________.

Per CMS policy, the prescriber must sign and date the prescription prior to delivery of the Negative Pressure Wound Therapy Pump

Physicians Signature______________________ **NPI#**________________ **Date**__________

By my signature, I attest that I am prescribing the Smith & Nephew Negative Pressure Wound Therapy Pump and supplies as medically necessary and all other applicable treatments have been tried or considered and ruled out. I understand that the NPWT Pump is contraindicated with malignancy in the wound, untreated osteomyelitis, non-enteric and unexplored fistula, and/or necrotic tissue with eschar present. I am not placing a NPWT pump dressing over exposed blood vessels or organs.

WOUND TYPE AND SUPPLIES

Please check the primary wound type(s) covered by this prescription, even if debrided:

___Stage III Pressure Ulcer
___Stage IV Pressure Ulcer
___Diabetic Ulcer
___Surgical
___Dehisced(disrupted)
___Other ________________

___Arterial Ulcer(arterial insufficiency)
___Venous Stasis Ulcer
___Trauma (orhtopedic)
___Trauma (soft tissue/open wounds)
___Amputation-Diabetic

___Amputation-Traumatic
___Graft(post-op)
___Flap(post-op)
___Fistula (enteric)**
___Burns (partial thickness/2nd degree)**
**Not currently covered by Medicare

Dressing types - PLEASE SELECT PUMP AND CIRCLE DRESSING TYPE AND SIZE

PUMP:	**DRESSING TYPE:**	**DRESSING SIZE:**
____**RENASYS EZ** *non ambulatory	**ANTIMICROBIAL GAUZE**	**SMALL** **MEDIUM**
____ **RENASYS GO PORTABLE** *ambulatory	**RENASYS FOAM**	**LARGE** **EXTRA- LARGE**

Prescriber's goal for completion of therapy:

____Assist granulation tissue formation ____Flap ____Graft ____Delayed primary closure (tertiery)

____Complete epithelielization (explain why) ________________ ____Other ________________

Physician's Printed Name: ________________ Phone#________________ Fax#________________

Physicians Address ________________ City ________________ State _____ Zip________

If the clinical condition of the wound(s) requires more than 15 dressings per wound or 10 canisters per month, a Letter of Medical Necessity must be completed by the clinician. If NWPT Pump Therapy is required for more than 4 months, a Letter of Medical Necessity is required

CLINICAL CARE CONTACT

Provider of clinical care (e.g.dressing changes) ________________

Contact Name ________________ Telephone # ________________ E-mail Address ________________

PATIENT'S DEMOGRAPHICS

Delivery Address ________________ City________________ State_____ Zip_______

Telephone # ________________ Date of Birth ________________ Social Security # ________________

Next of Kin / Contact Person ________________ Telephone # ________________

Insurance Information:

Primary: ___ Medicare ___ Private Insurance HIC # ________________
Name of Ins Co: ________________ Insurance Telephone # ________________
Policy ID # ________________ Group # (if applicable) ________________

Secondary: ___ Medicare ___ Private Insurance HIC # ________________
Name of Ins Co: ________________ Insurance Telephone # ________________
Policy ID # ________________ Group # (if applicable) ________________

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CLINICAL DATA

NEGATIVE PRESSURE WOUND THERAPY

Patient Name: ______________________ Social Security # ______________

Name of person completing form ______________________ Phone # ______________

Wound profile information in these sections may not be completed by the supplier. If more than two wounds are to be treated, additional Clinical information page(s) are required

Patient and Wound Information

1) Was Negative Pressure Wound Therapy initiated in an inpatient facility? ___Yes ___ No If YES, complete the following:
Facility Name ______________________ Therapy Start Date ______________

2a) Is there anything compromising the patient's nutritional status? ___Yes ___No If YES, answer 2b.

2b) If YES, what measures have been taken? ___ Protein supplements ___ Vitamin Therapy
___ Special Diet ___ Enteral/NG Feeding ___ TPN ___ Other ______________

3a) Is Negative Pressure Wound Therapy being ordered for any type of chronic wound (>30 days) ___ Yes ___ No

3b) If YES, which previous therapies have been applied to maintain a moist wound environment? ___ Absorptive
___ Saline Soaked Gauze ___ Hydrocolloid ___ Hydrogel ___ Alginate ___ Other ______________

4) Is the patient on a comprehensive diabetic management program? ___ Yes ___ No ___ N/A

Wound Type Information **- Complete only the section for the type of wound being treated. If more than two wounds are being treated, additional clinical information pages are required.**

5a) ___ Ulcers, Pressure: ___ Stage III ___ Stage IV
Is the patient being turned & positioned? ___Yes ___ No
Is a specialized support surface being utilized for ulcers on the posterior trunk or pelvis? ___ Yes ___ No ___ N/A
Is moisture/incontinence being managed? ___YES ___ NO

5b) ___ Ulcers, Diabetic and/or Neuropathic
Is foot ulcer pressure being reduced? ___ Yes ___ No ___N/A

5c) ___ Wounds, Traumatic, Surgical, or Dehisced
Is the wound a direct result of an accident? ___ Yes ___ No
Cause of accident? ___ Auto ___ Employment ___ Abuse
___Another party responsible ___ Other ______________
Date of Accident ______________

5d) ___ Ulcers, Venous Stasis
Are compression bandages/garments being consistantly applied? ___ Yes ___ No
Is leg elevation/ambulation being encouraged?
___ YES ___ NO ___ N/A

5e) ___Ulcers,Chronic including Arterial Insufficiency
Is pressure over the wound being relieved?
___ Yes ___ No ___ N/A
Is moisture/incontinence being controlled?
___ Yes ___ No ___ N/A

6a) Wound #____, Type: ______________ Measurement Date: ______________ L:___cm W:___cm D:___cm
Wound age(mos) ______ Location ______________ If depth varies, document the greatest depth
Has eschar been removed from the wound? ____ Yes ____ No Is there < 20% slough/fibrin in the wound? ____ Yes ____ No
If No, are serial debridements required? ____ Yes ____ No
Exudate ________cc/day Sinus/Tunnel#1:___cm at___o'clock Sinus/Tunnel#2___cm at___o'clock ___Sinus/tunnel#3___cm at___o'clock
Undermining #1____cm at____o'clock Undermining # 2____cm at____o'clock

6b) Wound #____, Type: ______________ Measurement Date: ______________ L:___cm W:___cm D:___cm
Wound age(mos) ______ Location ______________ If depth varies, document the greatest depth
Has eschar been removed from the wound? ____ Yes ____ No Is there < 20% slough/fibrin in the wound? ____ Yes ____ No
If No, are serial debridements required? ____ Yes ____ No
Exudate ________cc/day Sinus/Tunnel#1:___cm at___o'clock Sinus/Tunnel#2___cm at___o'clock ___Sinus/tunnel#3___cm at___o'clock
Undermining #1____cm at____o'clock Undermining # 2____cm at____o'clock

6c) If wound length, width, or depth information (i.e., a flap, graft, or stasis ulcer without significant depth) is non-applicable, please explain: