

PATIENT DELIVERY INFORMATION

Requested Delivery Date: _____ Requested Delivery Time: _____

Patient Name: _____ Patient DOB: _____

Address: _____ City/State/ZIP: _____

Patient Cell Phone: _____

Hospital Delivery: Deliver to Hospital Utilizing Consignment Pump – No Delivery Needed

Hospital/Facility Name: _____

Room Number: _____ Direct Phone Number to Patient's Room: _____

Anticipated Hospital/Facility Discharge Date: (if applicable)* _____

** Medicare allows delivery to a hospital/facility up to 48 hours prior to anticipated discharge for the purpose of fitting and training.*

Home Delivery: Deliver to Patient's Home? Yes No Same Address as Listed on Form

OR

Deliver to Alternate Address

Alternate Address: _____ City/State/ZIP: _____

PATIENT FOLLOW-UP CARE

Name of Home Health Agency Following the Patient: _____

Phone: _____ Fax: _____

Name of Wound Care Clinic Following the Patient: (if applicable) _____

Phone: _____ Fax: _____

REQUIRED DOCUMENTATION CHECKLIST

PLEASE ATTACH THE FOLLOWING:

Face Sheet

Pre-Op Report

Current Wound Notes

Physician Face-to-Face
Notes

Post-Op Report

Prior Treatments *(if chronic
wound)*



NEGATIVE PRESSURE WOUND THERAPY – ORDER FORM

Please Send Both Pages to Rotech's NPWT Department:

FAX • 866-233-7102 EMAIL • npwt@rotech.com CUSTOMER SERVICE • 844-592-5068

Referral Name & Title: _____ Referral Location: _____

Order Date: _____ Phone: _____ Fax: _____

Patient Name: _____ DOB: _____

Patient Address: _____ City/State/Zip: _____

Home Phone: _____ Mobile: _____ Email: _____

Insurance Provider: _____ Insurance ID#: _____

Secondary Insurance: _____ Insurance ID#: _____

Diagnosis Code(s) ICD-10: _____

I prescribe a Negative Pressure Wound Therapy Pump, and up to 15 Wound Care Sets/Dressing Kits per wound per month and 10 Canister Sets per month. Number of Months: 1 Month 2 Months 3 Months 4 Months Other _____ Pressure Setting: 100 120 140 Other _____ Frequency of Dressing Changes _____

OR Alternatively... I prescribe the Negative Pressure Wound Therapy Pump and up to _____ Dressing Kits (quantity) per wound per month, and _____ Canister Sets (quantity) per month.

SUPPLIES FOR DELIVERY (Please check ONE box for Foam or Gauze, and check ONE box for Size)

Dressing Kit: Foam Gauze **Size:** Small Medium Large **Other Supplies:** _____ (Y-Connectors, Gauze Rolls, etc.)

CURRENT WOUND MEASUREMENTS

Wound Location: (Please attach additional information if more than one wound present)

#1: _____ Age: _____ Measurement Date: _____ Necrotic tissue present? YES NO
Length: _____ Width: _____ Depth: _____
Tunneling: YES NO Location: From _____ o'clock to _____ o'clock
Undermining: YES NO Location: From _____ o'clock to _____ o'clock

Wound History: Was NPWT initiated in an inpatient facility? YES NO Date: _____

Is there anything compromising the patient's nutritional status? YES* NO *If YES, what measures have been taken?

Is the patient on a comprehensive diabetic management program? YES NO N/A

Is NPWT being ordered for any type of chronic wound (>30days or more)? YES* NO
*If YES, which previous wound treatments have been applied to maintain a moist wound environment to promote healing?

For Stage 3 & 4 Pressure Ulcers: Is the patient using a group 2 or 3 support surface? YES NO

Is patient on a turning schedule? YES NO Is moisture and incontinence being managed? YES NO

For Diabetic and or Neuropathic Ulcers: Is pressure on the foot being reduced with proper modalities? YES NO N/A

By signing and dating, I attest that I am prescribing Negative Pressure 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 therapy clinical guidelines. Additionally, I have reviewed the information provided in this form and attest to its accuracy.

PHYSICIAN NAME: _____ **NPI#:** _____

PHONE: _____ **FAX:** _____

ADDRESS: _____ **CITY/ST/ZIP:** _____

PHYSICIAN SIGNATURE: _____ **DATE:** _____