Fax to (847) 904-6804
Phone (847) 904-6803

Negative Pressure Wound Therapy Order Form

Total Home Health
RESPIRATORY & MEDICAL EQUIPMENT

PATIENT INFORMATION

Order date: _____

Patient Name: _____ DOB: _____
Last First MI

Home Address: _____ Phone: _____

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

REFERRAL INFORMATION

Referral Facility: _____ Contact Name: _____

Phone #: _____

PLEASE SEND PATIENT DEMOGRAPHICS/INSURANCE INFORMATION ALONG WITH CHART NOTES

DELIVERY INFORMATION

Requested Delivery Date: _____ Requested Delivery Time: _____

Delivery Location: ☐ Home - SAME ADDRESS AS ABOVE ☐ Other: _____

☐ Hospital/Facility: _____

Room Number: _____

PRESCRIPTION, ATTESTATION AND TREATING PRESCRIBER'S INFORMATION

This form is required unless a separate detailed written order for NPWT is provided. Prescriber must clearly document in the patient's medical record that other modalities have been tried, or clearly document why other modalities are being ruled out.

Diagnosis Code ICD-10. Write in complete code(s): _____

PHYSICIAN'S ORDER

I prescribe a Negative Pressure Wound Therapy Pump (E2402), and up to 15 dressing kits (A6550) per wound per month and up to 10 canisters (A7000) per month.

Pressure Setting: _____ ☐ Continuously ☐ Intermittently **Frequency of Dressing Changes:** _____

For the following wound type: ☐ Surgical ☐ Dehisced ☐ Traumatic ☐ Pressure Ulcer ☐ Venous/Arterial Ulcer
☐ Neuropathic/Diabetic Ulcer ☐ Chronic Mixed Etiology (≥ 30 Days)

Wound Location: _____

Goal of NPWT: ☐ Assist granulation tissue formation ☐ Delayed Primary Closure ☐ Flap/Graft

Length of Need (Anticipated): ☐ **1 Month** ☐ **2 Months** ☐ **3 Months** ☐ **4 Months** (Medicare allows 4 months with wound improvement)

☐ **Other:** _____

Dressing Kits			
Foam:	☐ Small	☐ Medium	☐ Large
Gauze:		☐ Medium	☐ Large

Miscellaneous Supplies
_____
_____

PRESCRIBER INFORMATION

Prescriber Name: _____

Address: _____ City: _____ ST: _____ Zip: _____

Phone: _____ Fax: _____

Prescriber Only to Complete—Original Signature and Date Required. No Stamps

Prescriber Signature: _____ Date: _____

NPI #: _____

By signing and dating. I attest that I am prescribing Negative Pressure Wound Therapy (NPWT) 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 NPWT product. I also understand NPWT contraindications. Additionally, I have reviewed the information provided in this form and attest to its accuracy.

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Patient Name:_____ DOB: _____

PATIENT FOLLOW-UP CARE

Home Health Agency Name:_____ Phone:_____

Wound Clinic Name: _____ Phone:_____

COMMON ICD-10 CODES FOR NEGATIVE PRESSURE WOUND THERAPY

Since NPWT is not diagnosis-driven, there is not a defined set of codes that must be used with this equipment. There are many other ICD-10 codes for which Negative Pressure Wound Therapy can be used. This is simply a short list of commonly used codes. Presence of an ICD-10 code alone does not guarantee coverage of a NPWT device.

A specific ICD-10 code must be provided either on page 1 or in the patient's chart notes. Please list the appropriate qualifying diagnosis and write in the code. Ranges will not be accepted.

ICD-10	Description	ICD-10	Description
I83.001 – I83.229	Varicose Veins with Ulcer	L89.130 – L89.229	Pressure Ulcer of Lower Back, Hip
I87.2	Venous Insufficiency (Chronic) (Peripheral)	L89.300 – L89.319	Pressure Ulcer of Buttock
L03.90	Cellulitis, Unspecified	L89.500 – L89.629	Pressure Ulcer of Lower Limb
L03.115 – L04.3	Cellulitis of Limb	T81.30XA – T81.30XS	Disruption of Wound, Unspecified
L05.01	Pilonidal Cyst with Abscess	T81.31XA – T81.31XS	Disruption of External Operation (Surgical) Wound
L89.004 – L89.894	Pressure Ulcer, Stage IV		

WOUND TYPE *(Complete in full OR fax wound history documentation)*

☐ **Pressure Ulcer:** ☐ Stage III ☐ Stage IV
Is patient being turned/positioned? ☐ YES ☐ NO
Has a group 2 or 3 surface been used for ulcer located on the posterior trunk or pelvis? ☐ YES ☐ NO
Are moisture and/or incontinence being managed? ☐ YES ☐ NO
Is pressure ulcer greater than 30 days? ☐ YES ☐ NO

☐ **Diabetic Ulcer/Neuropathic Ulcer:**
Has a reduction of pressure on the foot ulcer been accomplished with appropriate modalities? ☐ YES ☐ NO

☐ **Venous Statis Ulcer/Venous Insufficiency:** Are compression bandages and/or garments being consistently applied? ☐ YES ☐ NO
Is elevation/ambulation being encouraged? ☐ YES ☐ NO

☐ **Arterial Ulcer/Arterial Insufficiency:** Is pressure over the wound being relieved? ☐ YES ☐ NO

☐ **Surgical:** Wound surgically created and not represented by descriptions above? ☐ YES ☐ NO

Description of surgical procedure: _____Date of surgical procedure involving wound: _____

☐ **Chronic Ulcer of Mixed Etiology** (describe):_____

☐ **Other Wound Type** (describe): _____

CLINICAL WOUND INFORMATION *(please submit supporting documentation)*

WOUND #1

Was NPWT utilized within the last 90 days? ☐ YES ☐ NO
*If YES, date initiated:*_____
Is the patient's nutritional status compromised? ☐ YES ☐ NO
If YES, please attach nutritional plan.
Is osteomyelitis present in the wound? ☐ YES ☐ NO
*If YES, treated with:*_____
Is malignancy present in the wound? ☐ YES ☐ NO
Is there a open fistula to an organ or body cavity within the vicinity of the wound? ☐ YES ☐ NO
Which therapies were utilized to maintain a moist wound environment?
☐ Saline/Gauze ☐ Hydrogel ☐ Alginate ☐ Hydrocolloid
☐ Absorptive ☐ Other: _____
Wound location: _____ Wound Age: _____
Is wound full thickness: ☐ YES ☐ NO
Length: _____ cm **Width**: _____ cm **Depth:** _____ cm
Measurement Date: _____ **Exudate Amount (daily):** _____
Exudate Type: _____ **Odor:** ☐ YES ☐ NO
Please check what is exposed:
☐ Muscle ☐ Tendon ☐ Bone ☐ None
Is there tunneling? ☐ YES ☐ NO
*If YES, Location #1*_____ *cm, @* _____*o'clock*
*Location #2*_____ *cm, @* _____*o'clock*
Is there undermining? ☐ YES ☐ NO
*If YES, Location #1*_____ *cm, @* _____*o'clock*
*Location #2*_____ *cm, @* _____*o'clock*
Has a debridement been performed in the past 10 days? ☐ YES ☐ NO
If YES, Debridement Date: _____ **Debridement Type:** _____
*Debridement needs to be attempted for the presence of necrotic tissue

WOUND #2

Was NPWT utilized within the last 90 days? ☐ YES ☐ NO
*If YES, date initiated:*_____
Is the patient's nutritional status compromised? ☐ YES ☐ NO
If YES, please attach nutritional plan.
Is osteomyelitis present in the wound? ☐ YES ☐ NO
*If YES, treated with:*_____
Is malignancy present in the wound? ☐ YES ☐ NO
Is there a open fistula to an organ or body cavity within the vicinity of the wound? ☐ YES ☐ NO
Which therapies were utilized to maintain a moist wound environment?
☐ Saline/Gauze ☐ Hydrogel ☐ Alginate ☐ Hydrocolloid
☐ Absorptive ☐ Other: _____
Wound location: _____ Wound Age: _____
Is wound full thickness: ☐ YES ☐ NO
Length: _____ cm **Width**: _____ cm **Depth:** _____ cm
Measurement Date: _____ **Exudate Amount (daily):** _____
Exudate Type: _____ **Odor:** ☐ YES ☐ NO
Please check what is exposed:
☐ Muscle ☐ Tendon ☐ Bone ☐ None
Is there tunneling? ☐ YES ☐ NO
*If YES, Location #1*_____ *cm, @* _____*o'clock*
*Location #2*_____ *cm, @* _____*o'clock*
Is there undermining? ☐ YES ☐ NO
*If YES, Location #1*_____ *cm, @* _____*o'clock*
*Location #2*_____ *cm, @* _____*o'clock*
Has a debridement been performed in the past 10 days? ☐ YES ☐ NO
If YES, Debridement Date: _____ **Debridement Type:** _____
*Debridement needs to be attempted for the presence of necrotic tissue