Williams Bros.
HEALTH CARE PHARMACY
Focused on your health since 1899.

Phone: 800-264-0064
Fax: 812-257-2509 or 812-645-3805

Negative Pressure Wound Therapy – Physician Order

Order Date: _____

Patient Name: _____ DOB: _____

Address/Facility: _____

☐ **Provide a negative pressure wound therapy pump (E2402) and:**

(Select One)

☐ **Use 150ml (Medela Invia® Motion™) canister set (A7000) and change when full or weekly**
☐ **Use 300ml (Medela Invia® Liberty™) canister set (A7000) and change when full or weekly**

☐ **Dispense _____ Canister sets per month**, (maximum = 10)

Select one:

☐ **Constant Pressure of – _____mmHg**
or
☐ **Intermittent Pressure of – _____mmHg**
Time on: _____ minutes (range 1 – 8 minutes)
Time off: _____ minutes (range 1 – 8 minutes)

To the following wound(s) with the identified dressing(s) (A6550)

Wound #1	**Wound #2**
Location: Dressing type: ☐ Black Foam ☐ White Foam ☐ Gauze, Antimicrobial Change dressing: _____ X week for _____ weeks Dispense _____ dressings per month (max = 15) Specific Dx: ICD-10 Code:	Location: Dressing type: ☐ Black Foam ☐ White Foam ☐ Gauze, Antimicrobial Change dressing: _____ X week for _____ weeks Dispense _____ dressings per month (max = 15) Specific Dx: ICD-10 Code:
Wound #3	**Wound #4**
Location: Dressing type: ☐ Black Foam ☐ White Foam ☐ Gauze, Antimicrobial Change dressing: _____ X week for _____ weeks Dispense _____ dressings per month (max = 15) Specific Dx: ICD-10 Code:	Location: Dressing type: ☐ Black Foam ☐ White Foam ☐ Gauze, Antimicrobial Change dressing: _____ X week for _____ weeks Dispense _____ dressings per month (max = 15) Specific Dx: ICD-10 Code:

Other: _____

Ordering Physician Signature: _____ Date: _____

Printed Physician Name/Title: _____/_____ NPI: _____

Please review and sign then fax to Williams Bros at: 812-257-2509 or 812-645-3805

NPWT Wound Care Clinical Checklist

Patient Name: _____DOB _____/_____/_____

**** Attach Patient Demographics and Insurance Information **FAX COMPLETED FORM TO: 812-257-2509 or 812-645-3805**

Section 1: Wound Information/Assessment/Measurements

Type: _____ Wound #____Date Acquired: ___/___/___ Wound Location _____Bone/Tendon Exposed? ❑Yes ❑No Is there <20% eschar present in the wound? ❑Yes ❑No Is this a full thickness wound? ❑Yes ❑No Has debridement been attempted in the last 10 days? ❑Yes ❑No If Yes, Debridement date: _____/_____/_____ Debridement type: ❑Sharp ❑Mechanical ❑Autolytic ❑Other Measurement info: Date: _____/_____/_____ Length: _____cm Width: _____cm Depth: _____cm Exudate type: ❑Serous ❑Serosanguinous ❑Other Is there undermining? ❑Yes ❑No Location #1:_____ cm, from _____ to _____ o'clock Location #2:_____ cm, from _____ to _____ o'clock Is there tunneling? ❑Yes ❑No Location #1:_____ cm, at _____ o'clock Location #2:_____ cm, at _____ o'clock	Type: _____ Wound #____Date Acquired: ___/___/___ Wound Location _____Bone/Tendon Exposed? ❑Yes ❑No Is there <20% eschar present in the wound? ❑Yes ❑No Is this a full thickness wound? ❑Yes ❑No Has debridement been attempted in the last 10 days? ❑Yes ❑No If Yes, Debridement date: _____/_____/_____ Debridement type: ❑Sharp ❑Mechanical ❑Autolytic ❑Other Measurement info: Date: _____/_____/_____ Length: _____cm Width: _____cm Depth: _____cm Exudate type: ❑Serous ❑Serosanguinous ❑Other Is there undermining? ❑Yes ❑No Location #1:_____ cm, from _____ to _____ o'clock Location #2:_____ cm, from _____ to _____ o'clock Is there tunneling? ❑Yes ❑No Location #1:_____ cm, at _____ o'clock Location #2:_____ cm, at _____ o'clock

Section 2: Additional Information about Wound Type

Pressure Ulcer: ❑Stage III ❑Stage IV

Is a specialized support surface being used? ❑YES ❑ NO ❑N/A

Is the patient being turned and/or repositioned? ❑YES ❑ NO ❑N/A

Is moisture/incontinence being managed? ❑YES ❑ NO ❑N/A

Diabetic and/or Neuropathic Ulcer:

Is the wound being offloaded and pressure reduced? ❑YES ❑ NO ❑N/A

Venous Insufficiency/Venous Stasis:

Is compression therapy being utilized consistently? ❑YES ❑ NO ❑N/A

Arterial Insufficiency, Mixed Disease, Chronic Ulceration, or Unknown Etiology:

Is pressure being offloaded over the wound area? ❑YES ❑ NO ❑N/A

Is moisture being managed to the area of the wound bed? ❑YES ❑ NO ❑N/A

Other Wound Types: ❑Traumatic ❑Surgically Created ❑Dehisced Surgical

Section 3: Wound History

Is the patient's Nutritional status compromised? ❑YES ❑ NO

If YES, What treatment measures have been taken?

❑Supplements ❑Vitamins ❑Enteral/NG Feedings ❑TPN ❑Special Diet ❑Other_____

Does the patient have Diabetes? ❑YES ❑ NO

If YES, are they on a comprehensive diabetic management program? ❑YES ❑ NO

NPWT utilized in the last 90 days? ❑YES ❑ NO

If YES, Facility name _____ Date NPWT initiated ____/____/____

Is wound older than 90 days? ❑YES ❑ NO If YES, Biopsy performed? ❑YES ❑ NO

If YES, is Cancer present? ❑YES ❑ NO

What previous treatments have been used to promote moist wound healing?

❑Hydrogel ❑Saline Soaked Gauze ❑Absorptive ❑Hydrocolloid ❑Alginate ❑Other

Fistula present to organ or body cavity within vicinity of wound? ❑YES ❑ NO

Is there osteomyelitis present in the wound? ❑YES ❑ NO If YES, Treating with: _____

Home Health Care Agency: _____ Phone# _____/_____/_____

Name of Person Completing form: _____ Phone # _____/_____/_____