IMPACTMEDICAL

Customer Service 1.866.217.0372

Fax Orders to: 1.866.229.0034

Patient Name: _____ Social Security #: _____
Address:_____Phone:_____

PATIENT'S WOUND HISTORY

1. Will the NPWT be used in a ❒ Nursing Home/ Rehab ❒ Private Resident ❒ LTAC ❒ ALF ❒ Other _____
   Name of Facility: _____ Phone:_____ Date NPWT was initiated: __/__/__
2. Is there anything compromising the patient's nutritional status? ❒ Yes ❒ No
   If yes, what measures have been taken? ❒ Protein Supplements ❒ Enteral/NG Feeding ❒ TPN ❒Vitamin Therapy ❒Special Diet ❒ Other _____
3. Is the patient's wound a direct result of an accident? ❒ Yes ❒ No Date of accident: __/__/__
   Accident Type: ❒ Auto ❒ Employment ❒ Trauma ❒ Responsible Party: _____

ADDITIONAL INFORMATION BY WOUND TYPE (**CHECK ONLY ONE**)

a. ❒ **Pressure Ulcer: ❒ Stage III ❒ Stage IV**
Is moisture/incontinence being managed? ❒ Yes ❒ No ❒ N/A
Was Group 2 or 3 support surface used for ulcers on the posterior pelvis or trunk prior to and during NPWT? ❒ Yes ❒ No ❒ N/A
Is the patient being turned and positioned? ❒ Yes ❒ No ❒ N/A

b. ❒ **Diabetic and/or Neuropathic Ulcer/ Arterial Ulcer or Arterial insufficiency**
Is the patient on a comprehensive diabetic management program? ❒ Yes ❒ No ❒ N/A
Is pressure over wound being relieved? ❒ Yes ❒ No ❒ N/A

c. ❒ **Venous Insufficiency/ Venous Stasis**
Are compression bandages and/or garments being consistently applied? ❒ Yes ❒ No ❒ N/A
Is elevation/ambulation being encouraged? ❒ Yes ❒ No ❒ N/A

d. ❒ **Chronic Ulcer of Mixed or Unknown Etiology**
Thick callus surrounding wound must be debrided prior to NPWT. Was it? ❒ Yes ❒ No ❒ N/A
Wound must be present for more than 30 days. Was it? ❒ Yes ❒ No
List previous treatments applied to maintain a moist wound environment without wound responding: ❒ Saline Soaked Gauze
❒ Hydrocolloid ❒Alginate ❒ Hydrogel ❒ Absorptive ❒ Other _____

e. ❒ **Traumatic: Describe**_____ **Surgical: ❒ Dehisced ❒ Non-Dehisced**

WOUND MEASUREMENTS

Wound #1 Type: _____ Wound Age (mos): _____
Is there less than 20% slough/fibrin in the wound? ❒ Yes ❒ No
Was wound debrided recently? ❒ Yes ❒ No
If yes, date: _____
Are serial debridements required? ❒ Yes ❒ No
Is muscle, tendon or bone exposed? ❒ Yes ❒ No
Does wound has MRSA? ❒ Yes ❒ No

Measurement date: _____Wound Location: _____
Length: _____cm Width:_____ cm Depth: _____cm
Is there undermining? ❒ Yes ❒ No
Location #1: _____cm, from _____ to_____ o'clock
Location #2: _____cm, from _____ to_____ o'clock
Is there tunneling/sinus? ❒ Yes ❒ No
Location #1: _____cm, at _____ o'clock

ORGANIZATION PROVIDING THE PATIENTS CLINICAL CARE

Name of company:_____ Phone number: _____Fax:_____
Address:_____
Contact:_____

PRESCRIPTION, ATTESTATION AND PHYSICIAN INFORMATION **(Physician must sign & date)**

I prescribe Genadyne NPWT and up to 15 dressing kits, and 5 canister kits per month for ___ months, starting therapy on ____ for the following diagnosis:_____ ORDER: Cleanse wound with: _____,
Change dressing: (how often) _____, Setting to be placed at:_____ MMHG, ❒Foam ❒Gauze.
Goal at completion of NPWT: ❒ Assist granulation tissue formation ❒ Flap ❒ Graft ❒ Delayed primary closure

Physician Signature: _____ Date: _____
By my signature, I attest that I am prescribing Genadyne NPWT (No Substitute) as medically necessary and all other applicable treatments have been tried or considered and ruled out. I have read and understood all safety information and other instructions for NPWT as well as NPWT clinical guidelines.
Physician Name: _____ MD License _____ UPIN _____
Address: _____ City _____ State _____ Zip _____
Phone _____ Fax _____ NPI _____