

# Statement of Ordering Physician Negative Pressure Wound Therapy System (NPWT) Pump and Supplies



PLEASE PRINT ALL INFORMATION CLEARLY.

Patient Name \_\_\_\_\_ Order Date \_\_\_\_\_

Mdcr/Ins # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Initial \_\_\_\_\_ Ongoing \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Place of service where patient resides:  Home Care  ALF  ICF  LTC  Acute Care  Other: \_\_\_\_\_

Product: **NPWT Wound Pump** HCPC Code: **E2402** Charges: **\$1700.00** Allowable: **\$1551.85\***

Product: **Wound Drainage Kits** HCPC Code: **A6550** Charges: **\$50.00** Allowable: **\$24.80\***

Product: **Disposable Canister Set** HCPC Code: **A7000** Charges: **\$10.00** Allowable: **\$10.01\***

\* Varies by state.

Information in Sections A – D may NOT be completed by the supplier of the equipment. PLEASE COMPLETE ALL SECTIONS BELOW.

## A. GENERAL HEALTH INFORMATION

Patient height \_\_\_\_\_ Patient weight \_\_\_\_\_ Patient sex:  Male  Female

List all patient's diagnoses \_\_\_\_\_

Comorbid conditions or complications to healing \_\_\_\_\_

Patient's nutritional status:  Good  Fair  Poor Albumin level \_\_\_\_\_

Name and title of person answering questions if other than physician \_\_\_\_\_

## B. WOUND INFORMATION

Wound type (i.e. pressure, neuropathic, venous, arterial, chronic, traumatic, surgical, flap/graft, other) \_\_\_\_\_

Onset date of wound \_\_\_\_\_ Give brief history of the wound and what treatment has been tried \_\_\_\_\_

Wound location \_\_\_\_\_ Stage \_\_\_\_\_ Dimensions: Length \_\_\_\_\_ Width \_\_\_\_\_ Depth \_\_\_\_\_

Tunneling/Undermining:  Yes  No Drainage:  Yes  No If yes, amount & type \_\_\_\_\_

Infected:  Yes  No If yes, treatments ordered & dated started \_\_\_\_\_

Is there necrotic tissue present in the wound?  Yes  No If yes, will wound be debrided prior to application of NPWT?  Yes  No

Has the patient been on a comprehensive ulcer treatment program prior to application of NPWT?  Yes  No

If above answer is no, why will a conventional treatment NOT provide adequate healing? \_\_\_\_\_

Name and title of person answering questions if other than physician \_\_\_\_\_

(CONTINUED ON PAGE 2)

PLEASE FAX TO NATIONAL WOUND CARE AT 1-800-808-8768. Mail original to 2906 W. Clark Road, Champaign, IL 61822.  
**800-982-1835 nationalwound.com**

**Statement of Ordering Physician  
Negative Pressure Wound Therapy System (NPWT) Pump and Supplies  
(CONTINUED)**



(Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_)

**C. RELATED CLINICAL INFORMATION**

**Information for All Wounds:**

Has a care plan been established by the patient's physician or nurse?  Yes  No  N/A  
Regular assessment by a nurse, physician or other licensed healthcare provider?  Yes  No  N/A  
Nutritional assessment and interventions consistent with the overall plan of care?  Yes  No  N/A  
Appropriate management of moisture/incontinence?  Yes  No  N/A  
Moist wound environment maintained?  Yes  No  N/A  
If patient has been in an in-patient setting, was NPWT applied in facility?  Yes  No  N/A  
Has NPWT been utilized prior?  Yes  No If yes, what dates \_\_\_\_\_

**Information for Pressure Ulcer:**

Education of the patient and caregiver on the prevention and/or management of pressure ulcers?  Yes  No  
Appropriate turning, positioning and wound care?  Yes  No  
For posterior trunk/pelvis pressure ulcers, patient has been on a Group 2 or 3 Support Surface? (i.e. alternating pressure/low-air-loss mattress)  Yes  No

**Information for Diabetic Ulcer:**

Comprehensive diabetic management program?  Yes  No

**Information for Venous Ulcer:**

Compression bandages consistently applied?  Yes  No  
Leg elevation and ambulation have been encouraged?  Yes  No

**Information for Surgical Wounds:**

Date of surgery \_\_\_\_\_  
Have conventional post-surgical wound treatments been tried?  Yes  No  
If there is a need for faster wound healing, what conditions warrant this? \_\_\_\_\_  
\_\_\_\_\_  
If any of the above answers are no, please explain why this is not the case and why the NPWT should be tried in lieu of this? \_\_\_\_\_  
\_\_\_\_\_  
Additional observations/comments relating to wound \_\_\_\_\_  
\_\_\_\_\_  
Name and title of person answering questions if other than physician \_\_\_\_\_

**D. PHYSICIAN CERTIFICATION**

Estimated length of need in months (4 months maximum) \_\_\_\_\_ Date patient last seen \_\_\_\_\_  
Suction setting (i.e. 60 or 80 mmHg) \_\_\_\_\_ Check one:  Constant  Intermittent  
Physician name (print) \_\_\_\_\_ NPI# \_\_\_\_\_  
Physician signature \_\_\_\_\_ Date signed \_\_\_\_\_

**SIGNATURE AND DATE MUST BE HANDWRITTEN, NO STAMPS.**

**PLEASE FAX TO NATIONAL WOUND CARE AT 1-800-808-8768. Mail original to 2906 W. Clark Road, Champaign, IL 61822.  
800-982-1835 nationalwound.com**