Fitzsimmons
Home Medical Equipment
A Division of Fitzsimmons Surgical Supply, Inc

NEGATIVE PRESSURE WOUND THERAPY

To speak with our wound care center, please call (800) 972-8530

Please fax to (855) 337-0128

SECTION 1 PATIENT INFORMATION

Patient Name _____ Patient DOB _____

↓ Complete in Full **OR** Fax Demographics/Patient Face Sheet ↓

Address _____

City _____ State ____ Zip Code _____ Phone _____

Primary Ins. _____ Ins./Medicare ID (HIC#) _____

SECTION 2 PRESCRIPTION & PRESCRIBER INFORMATION

Start Date _____

Length of Need □ 1 month □ 2 months □ 3 months □ 4 months

Pressure Settings

□ Continuous
Pressure Setting (40-230) _____mmHg

□ Intermittent/Variable
Low Pressure Setting (0-220) _____mmHg Duration at Low (1-15) _____mins
High Pressure Setting (10-230) _____mmHg Duration at High (1-15) _____mins

Prescribing NPWT for: □ Pressure Ulcer(s) □ Diabetic Ulcer(s) □ Venous Ulcer(s) □ Arterial Ulcer(s)
□ Surgically Created □ Other _____

Description specific to wound etiology and include anatomical location(s) _____

Supplies for Delivery

Kits (select one from this row)	□ Foam	□ Gauze
Specialty	□ Y-connector □ Other_____	

Prescriber

Treating Prescriber Name_____

Prescriber Phone _____ NPI_____

PRESCRIBER ONLY TO COMPLETE. ORIGINAL SIGNATURE REQUIRED (NO STAMPS)

By signing and dating, I attest that I am prescribing the Negative Pressure Wound Therapy System 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. **I prescribe a Negative Pressure Wound Therapy Pump and 15 dressing (unless otherwise noted ____) per wound and 10 canisters (unless otherwise noted ____) per month.**

Prescriber Signature _____ Date_____

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SECTION 3 OPTIONAL – CLINICAL PROVIDER INFORMATION

Referral Information

Requester Name _____Title_____

Facility Name _____

Address _____ City _____ State ____ Zip _____

Phone _____ Fax_____

Name of Home Health Agency _____ Phone_____

If applicable:

Name of Wound Care Clinic following patient_____ Phone_____

Delivery Information

Initial Delivery to: □ Facility _____ Room # _____ □ Home Address □Temporary Address

Delivery Address _____ City _____ State____ Zip_____

Requested Delivery Date* _____ And Time _____

*Delivery to facility allowed up to 48hrs prior to anticipated discharge - Medicare Guideline

Additional Delivery Notes:

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Medicare requires medical records that corroborate information listed in Section 4 – based on wound type. Medicaid and commercial plans may vary.

SECTION 4 WOUND HISTORY & DOCUMENTATION CHECKLIST

Required for All Patients

□ Signed and dated written order from treating prescriber prior to delivery
□ Face Sheet and/or completed patient demographics
□ Medicare HIC# or insurance ID and group#
□ Wound measurements
□ History and Physical of wound (e.g. physician notes, wound clinic evaluation, progress notes)
□ If NPWT utilized within the last 90 days, date initiated _____
□ Prior therapies that have been tried and failed to maintain a moist wound environment (e.g. hydrogel)
□ Dietary consult documentation on nutrition (e.g. protein supplements, special diet, enteral tube)
□ Documentation of debridement (if applicable)

Required for Chronic Pressure Ulcer: Stage III □ or IV □

□ Turning and positioning regimen employed and documented
□ Moisture and incontinence management documentation (e.g. Foley catheter, bowel and bladder program)
□ If wound is located on posterior trunk or pelvis, documentation showing a low air-loss or alternating air mattress (i.e. group 2 or group 3 support surface) was used prior to NPWT
□ Duration of pressure ulcer (_____) days

Required for Traumatic or Surgical Wounds

□ Date of Surgery _____ or if traumatic please describe _____
□ Pre-operative report
□ Post-operative report
□ Additional supporting documentation required for wound complications (e.g. dehiscence, flaps or grafts)

Required for Diabetic/Neuropathic Ulcers

□ Documentation showing that pressure has been off-loaded from the wound area (e.g. foot ulcer)
□ Documentation of comprehensive diabetic management program (e.g. endocrinologist notes, diet, education provided, glucose readings, labs)

Required for Venous Stasis Ulcer

□ Documentation showing that compression bandages and/or garments have been consistently applied
□ Documentation that leg elevation and ambulation have been encouraged

Exclusions from Coverage

- Necrotic tissue with eschar is present in the wound and debridement has not been attempted
- Untreated osteomyelitis within the vicinity of the wound
- Cancer present in the wound
- The presence of an open fistula to an organ or body cavity within the vicinity of the wound