Sales Reps complete this section

Physicians only complete this section

Negative Pressure Wound Therapy Order Form

CORK MEDICAL

Phone _____

Referred By _____ Fax _____

Physician's Full Name _____ NPI _____

Patient Name _____ DOB _____ Height/Weight _____

PRODUCTS

- ☐ Negative Pressure Wound Therapy System with 15 Kits (A6550) & 10 Canisters (A7000)
- ☐ Hospital Bed with Low Air Loss Mattress
- ☐ Hospital Bed with Non-Powered Group 2 Mattress

Length of Need in Months: 1 2 3 4 Other _____

THERAPY SETTINGS

- ☐ Continuous Mode (40 mmHg – 200 mmHg) _____ mmHg
- ☐ Variable Intermittent Mode

Low Pressure (40-200) _____ mmHg Cycle Time (1 minute increments) _____

High Pressure (40-200) _____ mmHg Cycle Time (1 minute increments) _____

Notes: _____

Other Orders: _____

DIAGNOSIS (continues on pg. 2)

Wound Type: _____ Diagnosis Code(s): _____ Stage (if applicable)_____

Other Contributing Diagnoses: _____

CLINICAL INFORMATION

Y	N	n/a	1. Is the patient being seen regularly by a nurse, physician or other licensed practitioner?
Y	N	n/a	2. Has a care plan been established including ongoing nutritional assessments and consistent interventions?
Y	N	n/a	3. Is the wound full thickness?
Y	N	n/a	4. Is the moisture/incontinence being appropriately managed?
Y	N	n/a	5. Has the wound environment remained moist?
Y	N	n/a	6. Is there 20% or less eschar in the wound?
Y	N	n/a	7. Has NPWT therapy ever been utilized prior? If Yes, date: _____
Y	N	n/a	8. Has previous alternative treatment been tried prior to application of NPWT? If yes, what has been tried:

_____

Order Date _____

Physician Signature _____ **Signature Date** _____

By signing above I am authorizing the order of a Negative Pressure Wound Therapy System as medically necessary for the patient listed above. I am also proclaiming that all other applicable healing treatments have been attempted or considered and ruled out. I have read and understand all safety information and instructions for use included with this specific product as well as the systems it is contraindicated for: patients with malignancy of the wound, untreated osteomyelitis, non-enteric or unexplored fistulas, or necrotic tissue with the presence of eschar. Dressings for the Negative Pressure Wound Therapy system should never be placed directly in contact with exposed blood vessels, anastomotic sites, organs or nerves. I prescribe the Negative Pressure Wound Therapy system and up to 15 dressings per wound and 10 canisters per month.
*Physician Signature covers all sections on NPWT Order Form (page 1) and Statement of Ordering Physician (page 2).

Sales Reps complete this

Physicians only complete this section

NPWT Statement of Ordering Physician

Patient Name _____ DOB _____

WOUND INFORMATION

Wound Type: (Select Wound Type, then answer corresponding questions)

☐ **Trauma** (check one): ☐ Orthopedic ☐ Soft Tissue/Open Wound ☐ Traumatic Amputation

☐ **Surgical** **Date of Surgery:**_____

Y N 1. Have other post-operative wound healing techniques been attempted prior to ordering NPWT?

If "No", why is NPWT being ordered?

_____

_____

☐ **Pressure:** **Stage III** **or** **Stage IV** (circle one)

Y N 1. Has the patient been involved in a comprehensive ulcer treatment program?

Y N 2. Has the patient been on a Group 2 or 3 surface relieving the pressure on the trunk/pelvis?

If "No" why has it been ruled out?

_____

_____

☐ **Neuropathic & Diabetic**

Y N 1. Have prior pressure reducing techniques for the foot ulcer been attempted and failed?

☐ **Venous Stasis**

Y N 1. Are compression garments being consistently applied to the wound?

Y N 2. Does the plan of care include elevation or ambulation of the extremities?

☐ **Other: (i.e. Arterial, Burns)** _____

Description_____

_____

DIAGNOSIS (cont'd)

Wound #1 Description: _____

Location: _____

Length_____cm Width_____cm Depth_____cm

Undermining @_____o'clock _____cm

Tunneling @_____o'clock _____cm

Appearance of wound bed or odor: _____

_____

Amount of Exudate and Color: _____

Has debridement been attempted in the last 10 days?

☐ Yes ☐ No

If Yes, date: _____

Wound #2 Description: _____

Location: _____

Length_____cm Width_____cm Depth_____cm

Undermining @_____o'clock _____cm

Tunneling @_____o'clock _____cm

Appearance of wound bed or odor: _____

_____

Amount of Exudate and Color: _____

Has debridement been attempted in the last 10 days?

☐ Yes ☐ No

If Yes, date:_____

Please include most recent Chart Notes