

Supplemental Wound N.P.W.T. Order Form

Section A - Patient Information

- 1) Patient Name: (last) _____ (first) _____
 2) Social Security #: _____ 3) Patient Date of Birth: _____

Section B - Wound Information (Must Be completed by Clinician)

- 4) Wound Number 2 3 4 8) a) Is untreated osteomyelitis present within the vicinity of the wound? Yes No
 5) Wound Location _____ b) Is cancer present in the wound? Yes No
 6) Wound Age _____ months c) Is there a fistula to an organ or body cavity within the vicinity of the wound? Yes No
 7) Therapies utilized to maintain moist environment
 Saline/Gauze Hydrogel Alginate Other

Additional Dressing Types Requested:

- Black Foam Dressing Kit:
 Small (10cm x 8cm x 3cm) Medium (20cm x 12.5cm x 3cm) Large (25cm x 15cm x 3cm) White Foam
 Y Connectors Drape Only Speed Connect Tubing

9) **Wound Type** - Complete only the section for the type of wound being treated.

<input type="checkbox"/> Arterial Ulcers Pressure over wound relieved? Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	<input type="checkbox"/> Traumatic Orthopedic <input type="checkbox"/> Soft Tissue/Open Wound <input type="checkbox"/> Traumatic Amputation <input type="checkbox"/>
<input type="checkbox"/> Venous Stasis Ulcer Compression bandages/garments consistently applied? Yes <input type="checkbox"/> No <input type="checkbox"/> Leg elevation/ambulation encouraged? Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> Diabetic or Neuropathic Ulcer Patient on comprehensive diabetic management program? Yes <input type="checkbox"/> No <input type="checkbox"/> Foot ulcer pressure reduced with appropriate modalities? Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
<input type="checkbox"/> Pressure Ulcer - Stage III <input type="checkbox"/> Pressure Ulcer - Stage IV Patient appropriately turned and positioned? Yes <input type="checkbox"/> No <input type="checkbox"/> Support surface (Group 2 or 3) in use for wound(s) on trunk or pelvis? Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> Moisture/Incontinence Managed? Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	<input type="checkbox"/> Surgical Surgical (non-dehisced) <input type="checkbox"/> Dehisced (disrupted) <input type="checkbox"/> Flap (post-op) <input type="checkbox"/> Graft (post-op) <input type="checkbox"/> Necrotizing Fasciitis <input type="checkbox"/> Is there documentation of the medical necessity for accelerated formation of granulation tissue which is not achievable with other topical wound treatments? Yes <input type="checkbox"/> No <input type="checkbox"/>

- 10) a) Wound Bed: Red % _____ Yellow % _____ Black % _____ Total 100% _____
 b) Are Serial Debridements Required? Yes No
 c) Last Debridement Date: _____ d) Debridement Type: _____

11) Wound Measurements

- a) Current (within the last 7 days):
 Date: _____
 L: _____ cm W: _____ cm D: _____ cm
 Sinus/Tunnel #1: _____ cm @ _____ o'clock
 Sinus/Tunnel #1: _____ cm @ _____ o'clock
 Undermining: _____ cm @ _____ to _____ o'clock
 Exudate: ___ none ___ min ___ mod ___ heavy
- b) 1 or more months ago (if available):
 Date: _____
 L: _____ cm W: _____ cm D: _____ cm
 Sinus/Tunnel #1: _____ cm @ _____ o'clock
 Sinus/Tunnel #1: _____ cm @ _____ o'clock
 Undermining: _____ cm @ _____ to _____ o'clock
 Exudate: ___ none ___ min ___ mod ___ heavy

c) If wound measurements (length, width, or depth) is not applicable, please explain (i.e. flap, or graft, or venous stasis ulcer)

Printed name & title of individual providing information:	Employer:
Phone #:	Signature: _____ Date: _____