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Ensuring quality care from the first breath of life until the last; we'll be there every step of the way.

AEROFLOW HEALTHCARE

NEGATIVE PRESSURE WOUND THERAPY ORDER FORM

PATIENT INFORMATION

Patient Name:_____ Phone:_____

DOB:_____ SSN:_____ Sex: ☐ Male ☐ Female

Height:_____ Weight:_____

Address:_____

City:_____ State:_____ Zip:_____

1st Insurance:_____ Phone:_____

Policy #:_____ Group #:_____

2nd Insurance:_____ Phone:_____

Policy #:_____ Group #:_____

Alternate Contact:_____ Phone:_____

Relationship:_____

PHYSICIAN INFORMATION

Ordering Physician:_____ NPI #:_____

Practice Name: _____ Phone:_____ Fax:_____

Address:_____

City:_____ State:_____ Zip:_____

ITEMS TO BE DISPENSED (please select size)

☒ E2402 Medela Liberty NPWT Pump ☒ A7000 Medela Canister Kit (10 per month) Size: ☐ 300cc ☐ 800cc

☒ A6550 Medela Dressing Kit (15 per month) Size: ☐ S ☐ M ☐ L

Please attach and fax the below documentation, along with this form, to 1-800-249-1513

☐ Required for **Traumatic or Surgical Wounds**
- Date of surgery _____Facility location of Surgery _____
- Pre- and Post-operative report
- Additional Supporting Documentation required for complications of surgically created wounds (e.g. dehiscence, flaps or grafts)

☐ Required for **Chronic Pressure Ulcer** Stage III ☐ or IV ☐
- Duration of pressure ulcer _____ days
- Turning and positioning regimen employed and documented,
- Moisture and Incontinence management documented history,
- If wound is located on trunk or pelvis, documentation showing a low air-loss or alternating air mattress (i.e. group 2 or group 3 support surfaces) was tried prior to NPWT.

☐ Required for **Diabetic/Neuropathic Ulcers**
- Documentation showing that pressure has been off-loaded from the wound area,
- Documentation Of comprehensive diabetic management program. (E.g. endocrinologist notes, diet, education, glucose readings)

☐ Required for **Venous Stasis Ulcers**
- Documentation showing that compression bandages and/or garments have been consistently applied,
- Documentation that elevation/ambulation encouraged.

☐ Detailed Location of Wound: _____

I prescribe NPWT and up to 15 dressing kits (Unless otherwise noted_____),10 canisters per month (Unless otherwise noted_____) for _____ months, starting therapy on _____for the following diagnosis (Specify ICD-9 to the 4th or 5th digits)_____.

Anticipated hospital/facility discharge date* _____ Start pump on* _____

Medicare allows delivery to a facility up to 48 hours prior to anticipated discharge for the purpose of fitting/training

Pressure setting _____ Frequency of dressing changes_____

Physician's Signature:_____ Date: _____ NPI: _____

By my signature, I attest that I am prescribing NPWT 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.

PLEASE FAX THIS FORM AND ATTACH ALL WOUND DOCUMENTATION TO 1-800-249-1513

(EQUIPMENT DELIVERED WITHIN TWO HOURS)

Emergency Orders Please Call 1.888.345.1780