Invia® Wound Therapy

NPWT Order Form

Who should we contact for questions regarding this order?

Contact Name: _____

Direct Phone: _____ Fax: _____

PATIENT INFORMATION [Complete this section ONLY if you will not be supplying a Face Sheet that contains this information.]

Patient's Name (Last, First, MI):			☐ Male ☐ Female
Patient's DOB: _____/_____/_____ (mm/dd/yyyy)	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	Height: _____ (ft., in.)	Weight: _____ (lbs.)
Patient's Permanent Address:			
City:	State:	Zip:	Phone:
Invia® Wound Therapy will be used in what type of setting: ☐ Private Residence ☐ Assisted Living Please contact Medela if in: ☐ Skilled Nursing Facility ☐ Rehabilitation Center ☐ Acute Care Facility ☐ LTACH			
Delivery Address:	If a facility, Name:		
City:	State:	Zip:	Phone:
Delivery Contact:	Direct Phone:		

INSURANCE INFORMATION [Provide a copy of insurance card(s)]

Is the financial obligation for the patient's NPWT the responsibility of a party other than the patient or the patient's insurance (i.e., workman's comp, litigation, etc.)?

☐ No ☐ Yes ⇨ If Yes: Name of responsible party _____ Contact Phone:_____

PRIMARY INSURANCE: ☐ Medicare ☐ Private Insurance ☐ Medicaid		Group #:
Insurance Name:		Policy/ID #:
Insurance Address:		Phone:
Primary Care Physician **if not** Prescriber:		Phone:
SECONDARY INSURANCE: ☐ Medicare ☐ Private Insurance ☐ Medicaid		Group #:
Insurance Name:		Policy/ID #:
Insurance Address:		Phone:
TERTIARY INSURANCE: Insurance Name:		
Group #:	Policy/ID #:	Phone:

CLINICAL CARE PROVIDER INFORMATION [The organization that will be providing the patient's wound care.]

Name of Organization:		
Address:		
City:	State:	Zip:
Organization Phone:	Organization Fax:	
Organization Contact Name:	Direct Phone:	

Please include copies of all pertinent information from patient's medical record to validate the information provided here.

WOUND TYPE	
[Check only one wound type below. Complete a separate Secondary Wound Assessment Form for each additional wound.]	
☐ **1. SURGICALLY CREATED or DEHISCED WOUND**	
☐ **2. TRAUMATIC WOUND**	
☐ **3. PRESSURE ULCER:** ☐ **Stage III** ☐ **Stage IV** ⇨	A) Is the patient being appropriately turned/positioned? ☐ Yes ☐ No B) If patient's pressure ulcer is on the posterior trunk or pelvis, has a group 2 or 3 support surface been used? ☐ Yes ☐ No ☐ N/A C) Is moisture/incontinence being managed? ☐ Yes ☐ No
☐ **4. VENOUS/ARTERIAL ULCER** ⇨	A) Are compression bandages and/or garments being consistently applied? ☐ Yes ☐ No B) Is leg elevation/ambulation being encouraged? ☐ Yes ☐ No
☐ **5. NEUROPATHIC ULCER (e.g., diabetic ulcer)** ⇨	A) Has pressure on the foot ulcer been reduced with appropriate modalities? ☐ Yes ☐ No
☐ **6. CHRONIC ULCER/MIXED ETIOLOGY (present at least 30 days)** ⇨	A) Is pressure over the wound being relieved? ☐ Yes ☐ No ☐ N/A B) Is moisture/incontinence being managed? ☐ Yes ☐ No

WOUND HISTORY

1) Which therapies have been previously utilized to maintain a moist wound environment? [Check all that apply.]
   ☐ Saline/Gauze ☐ Hydrogel ☐ Alginate ☐ Hydrocolloid ☐ Absorptive ☐ Other: _____

2) Is the patient's nutritional status compromised? ☐ No ☐ Yes ⇨ If Yes, check the actions taken:
   ☐ Protein Supplements ☐ Enteral/NG Feeding ☐ TPN ☐ Vitamin Therapy ☐ Other: _____

3) Was NPWT utilized within the last 90 days? ☐ No ☐ Yes ⇨ If Yes: ☐ Inpatient ☐ Outpatient
   If Yes, Date initiated: _____/_____/_____ (mm/dd/yyyy) Facility Name: _____

4) Does patient have diabetes? ☐ No ☐ Yes ⇨ If Yes, is patient on a comprehensive diabetic management program? ☐ No ☐ Yes

5) Is there osteomyelitis present in the wound? ☐ No ☐ Yes ⇨ If Yes, treated with: _____

6) If wound is > 90 days, has a biopsy been done? ☐ No ☐ Yes ⇨ If Yes, is cancer in the wound? ☐ No ☐ Yes ⇨ (contraindicated)

7) Is there a fistula to an organ or body cavity within vicinity of the wound? ☐ No ☐ Yes ⇨ If Yes: ☐ Enteric ☐ Non-enteric ⇨ (contraindicated)

Additional medical documentation may be requested.

Please include copies of all pertinent information from patient's medical record to validate the information provided here.

WOUND MEASUREMENTS

[Complete a separate Secondary Wound Assessment Form for <u>each</u> additional wound.]

Wound Location: | Wound Age in Months:

Presence of necrotic tissue with eschar? ☐ No ☐ Yes* [Please obtain measurements after debridement.]

* If yes, type of debridement: ☐ Mechanical ☐ Chemical ☐ Sharp/Surgical ⇨ If Sharp/Surgical, date: _____/_____/_____ (mm/dd/yyyy)

Length: _____ cm Width: _____ cm Depth*: _____ cm

* If depth is less than or equal to 0.5 cm, please provide documentation whether underlying structures (such as bone, muscle, fascia) are exposed.

Measurement Date: _____/_____/_____ (mm/dd/yyyy)

Is there undermining? ☐ No ☐ Yes ⇨ If Yes, complete details below.

Location #1: _____ cm, from_____ to _____ o'clock

Location #2: _____ cm, from_____ to _____ o'clock

Is there tunneling/sinus? ☐ No ☐ Yes ⇨ If Yes, complete details below.

Location #1: _____cm, @_____o'clock

Location #2: _____cm, @_____o'clock

Exudate Type: ☐ Serous ☐ Serosanginous ☐ Other _____

Exudate Amount: ☐ < 100 ml/day ☐ > 100 ml/day

TO BE COMPLETED BY PRESCRIBER

PRESCRIPTION, ATTESTATION AND PRESCRIBER INFORMATION

Patient Name [print] (last) _____ (first) _____ (mi) _____

I prescribe Invia® Wound Therapy. This includes: an Invia® Wound Therapy suction pump, up to 15 wound dressing sets/per wound/per month and up to 10 canisters per month. The anticipated length of therapy is _____ month(s) starting on _____/_____/_____ (mm/dd/yyyy) for the following diagnosis (ICD-9-CM diagnosis code specific to 4th or 5th digit or narrative): _____

_____

Goal at the completion of Invia® Wound Therapy: ☐ Assist granulation tissue formation ☐ Delayed primary closure (tertiary)

Prescriber's Signature _____ Date _____/_____/_____ (mm/dd/yyyy)

Prescriber's Name [print] (last) (first) (mi)

Address: | City: | State: | Zip:

Phone: | Fax: | NPI:

PRODUCTS PROVIDED

Upon establishment of medical necessity, your DME will ship an Invia® Wound Therapy suction pump, 15 wound dressing sets per wound per month and 10 canisters per month. If you would like to make a special request for other supplies, please check here ☐ and a customer service representative will contact you regarding this.

Requested delivery date: _____/_____/_____ (mm/dd/yyyy) [Please allow **<u>at least 24 hours</u>** following review of completed form.]