BECN 16104006386

BINSON'S Medical Equipment & Supplies Since 1953

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Reset Form

Negative Pressure Wound Therapy

Written Order Prior to Delivery

Who should Binson's contact for questions regarding this order? Contact Name: _____

Order Date: _____ **Direct Phone:** _____ **Fax:** _____

Patient Resides In: (please check one) ☐ **Private Residence** ☐ **SNF** ☐ **Rehabilitation Center** ☐ **Acute Care Facility** ☐ **LTACH**			
Patient Name:			
Delivery Address:		**If a facility, name:**	
City:	**State:**	**Zip:**	**Phone:**
Delivery Contact:		**Direct 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:		

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

WOUND TYPE		
[Complete a separate Wound Assessment Form for <u>each</u> 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 service 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
	B) Has the patient been on a comprehensive diabetic management program?	☐ 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

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WOUND HISTORY

1) Is there a documented history of previous wound management regimen; including wound measurements available for review upon request? ☐ No ☐ Yes

2) Which therapies have been previously utilized to maintain a moist wound environment? [Check all that apply]

☐ Saline/Gauze ☐ Hydrogel ☐ Alginate ☐ Hydrocolloid ☐ Absorptive ☐ Other: _____

3) Is the patient's nutritional status compromised? ☐ No ☐ Yes **If Yes**, check the actions taken:

☐ Protein Supplements ☐ Enteral/NG Feeding ☐ TPN ☐ Vitamin Therapy ☐ Other: _____

4) Was NPWT utilized within the last 90 days? ☐ No ☐ Yes **If Yes:** ☐ Inpatient ☐ Outpatient

If Yes, Date initiated: _____/_____/_____ Facility Name: _____

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

6) Is the patient diabetic? ☐ No ☐ Yes If Yes, is the patient on a comprehensive diabetic management program? No ☐ Yes ☐

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

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

WOUND MEASURMEMENTS [Complete a separate Wound Assessment Form for each 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: _____/_____/_____

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: _____/_____/_____

Is there undermining? ☐ No ☐ Yes If Yes, complete the details below:	Is there tunneling/sinus? ☐ No ☐ Yes If Yes, complete the details below:
Location #1: _____cm, from _____to _____o'clock	Location #1: _____cm, @_____o'clock
Location #2: _____cm, from _____to _____o'clock	Location #2: _____cm, @ _____o'clock

Describe amount/color of exudate: _____

Appearance of wound bed/odor: _____

Attestation and Prescriber's Signature - *TO BE COMPLETED BY THE PHYSICIAN*

I prescribe: ☐ E2402 Negative Pressure Wound Therapy Electrical Pump, Stationary or Portable.

Length of Use: _____ mos. Anticipated Length of Therapy: _____ (Number of Months) _____ (Beginning Date)

NPWT Setting: ☐ 120mmHG ☐ 130 mmHG ☐ _____mmHG (10mmHg Increments only)

NPWT Mode: ☐ Continuous ☐ Intermittent: _____ Minutes On _____ Minutes Off _____ Change Dressing ____ Times Per Week

☒ A6550 Wound Care Sets for NPWT up to 15 per month per wound.

☒ A7000 Canisters up to 10 per month, per wound.

Date of Visit Prior to Order: _____ ICD 10 Code: _____

By signing & dating, I attest that I have seen the patient for a condition that supports the need and have discussed the need for this medical equipment with the patient and caregivers. I have documented the above medical necessity in the patient's most recent chart notes. All other applicable treatments have been tried or considered and ruled out. NPWT is contraindicated with malignancy in the wound, untreated osteomyelitis, non-enteric and unexplored fistula, necrotic tissue with eschar present. NPWT should not be placed directly in contact with exposed blood vessels, organs, nerves or anastomotic sites.

Physician Name & Credentials: _____

Physician Phone: _____ Physician Fax: _____ Physician NPI Number: _____

Prescribing Physician Signature: _____ Signature Date: _____

(stamped signature not accepted)

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