360 DEGREE Patient Care
provided by:
jayhawk pharmacy & patient supply
2620 SW 6th Ave
Topeka, KS 66606
785.235.9700 P 785.235.9703 F

NPWT Order Form

Who should we contact for questions regarding this order?
Contact Name: _____
Direct Phone: _____ Fax: _____

Patient Information:
Patient's name (Last, First, MI): _____ ☐ Male ☐ Female
Patient's Permanent Address: _____
City: _____ State: _____ Zip: _____ Phone: _____
Patient's DOB: _____ SS#: _____-_____-_____ Height: _____ Weight: _____

Delivery Information: [check if same as permanent address: ☐]
Name of Facility (if applicable): _____
Delivery Address: _____
City: _____ State: _____ Zip: _____ Phone: _____

Insurance Information: [provide a copy of insurance card(s)]
Primary Insurance: ☐ Medicare ☐ Private Insurance ☐ Medicaid Group #: _____
Insurance Name: _____ Policy/ID #: _____
Insurance Address: _____ Phone #: _____

Secondary Insurance: ☐ Medicare ☐ Private Insurance ☐ Medicaid Group #: _____
Insurance Name: _____ Policy/ID #: _____
Insurance Address: _____ Phone #: _____

Tertiary 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: _____
Primary care physician (if different than prescriber): _____ Phone #: _____

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 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
☐ **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: [additional medical documentation may be requested]

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

☐ Saline/Guaze ☐ 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: _____ 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]

Wound Measurements

jayhawk pharmacy & patient supply
Please fax documents to 785-235-9703
2620 SW 6th Ave Suite E, Topeka, KS 66606-1868
(p) 785-235-9700

[Complete a separate Secondary Wound Assessment For <u>each</u> additional wound.]	
Wound Location:	Wound Age in Months:
Presence of necrotic tissue with eschar? ☐ No ☐ Yes [Please obtain measurements after debridgement] → If yes, type of debridgement: ☐ 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 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's 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 _____ (date) 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 _____

Prescriber's Name [print] (last)	(first)	(mi)	
Address:	City:	State:	Zip:
Phone:	Fax:	NPI:	

Products Provided

Upon establishment of medical necessity, Jayhawk Patient Supply 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 contact us at 785-235-9700.

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

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