PERSONALSUPPORT
Medical Suppliers

EXTRICARE NEGATIVE PRESSURE WOUND THERAPY

Please fax this form to PERSONAL SUPPORT MEDICAL SUPPLIERS at **215-464-7308**

Account Manager:

1 Patient Information:

Patient Name (print) Last: _____ First: _____ Patient DOB: ___/___/___

(skip completing patient's home address if demographic/insurance sheet submitted)

Home Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____ Phone #: _____

Emergency Contact (if available): _____

Primary Insurance: _____ Policy# _____ 2nd Ins: _____ Policy# _____

2 Prescriber Information (Complete in full or fax written prescription to include the following)

I prescribe Extricare NPWT Pump for the following wound type(s): Pressure Ulcer(s) ☐ Diabetic Ulcer(s) ☐ Venous Ulcer(s) ☐

Arterial Ulcer ☐ Surgically Created ☐ Other _____

Provide narrative description specifying wound etiology and including anatomical location(s): _____

I prescribe Extricare NPWT Pump for: ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months Other(weeks) _____

and up to 15 dressings per wound, per month and up to 10 canisters per month.

Starting Date Therapy: ___/___/___ (If starting therapy is blank, use my signature date as start of therapy)

Treating prescriber name (print) Last: _____ First: _____

Address: _____ City: _____ State: _____ Zip: _____

Prescriber Phone: _____ Fax: _____ Email: _____ **NPI:** _____

Prescriber Only to Complete Original Signature Required. No Stamps

Prescriber Signature: _____ Date: ___/___/___

By signing and dating, I attest that I am prescribing the **Extricare Negative Wound Therapt Pump** as medically necessary, and all other applicable treatments have been tried or considered and ruled out. I have read and understand all safety information, as well as the NPWT Clinical Guidelines.

The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) state that beyond the first four months of thera py, "to justify the need for each additional month of coverage, a new prescription for each month is required," in addition to supporting medical records that document medical need.

3 Supplies for Delivery Please check the Dressing(s) requested (up to 15)

A6550	Type of Dressing	Dressing Size	Dressing Pad Size
☐	Mini Oval EC2400-MN	120 mmx 130 mm (4.7" x 5.1")	50 mm x 60mm (2.0"x2.3")
☐	Small Oval EC2400·SO	160 mmx 180mm(6.3"x7.1")	80 mm x 100 mm (3.1" x 3.9")
☐	Large Oval EC2400-LO	192 mmx 270 mm (7.6" x 10.6")	77 mm x 152 mm (3.0" x 6.0")
☐	Extra Large Oval EC2400-IM	140 mm x 310 mm (5.5" x 12.2")	72 mm x 220 mm (2.8" x 8.7")
☐	Sacral EC2400-S	245 mm x 225 mm (9.6" x 8.9")	140 mmx 125 mm (5.5" x 5.0"')
☐	Foot EC2400-F	350 mm x 280 mm (13.8" x 11.0")	320 mmx 100 mm (12.6" x 3.9")
☐	Large Black Foam Kit EC-FOAM-L	25 cm x 16 cm foam	

A7000 Canisters: (up to 10)

☐ 110cc

☐ 400cc

Other Dressing: _____

4 Requestor & Post-Acute Clinical Provider Information (Please complete in full)

Requestor Name: _____ Title: _____

Requestor Facility Name: _____ Phone: _____ Fax: _____

Delivery Location: ☐ Home ☐ Facility/ RM#: _____ ☐ Other _____

Delivery Address: _____ City: _____ State: _____ Zip: _____

WCC Post-Acute Clinical Provider administering Dressing Changes: Name: _____ Phone: _____

PERSONALSUPPORT
Medical Suppliers

Please fax this form to Personal Support Medical Suppliers at **215-464-7308**

Patient Name:_____ D.O.B.:____/____/_____ Completed by:_____

5a Clinical Information by Wound Type

1. Was NPWT initiated in an inpatient facility? Yes ☐ No ☐ Date Initiated:_____/ _____/ _____
   OR has the patient been on NPWT anytime during the last 60 days? Yes ☐ No ☐ Facility Name: _____
2. Is the patient's nutritional status compromised? Yes ☐ No ☐ Facility City, St: _____
   If Yes, check the action taken: ☐ Protein Supplements ☐ Enteral/NG Feeding ☐ TPN ☐ Vitamin Therapy ☐ Special Diet
3. Indicate other therapies that have been previously tried and/or failed to maintain a moist wound environment:
   ☐ Saline Gauze ☐ Hydrogel ☐ Alginate ☐ Hydrocolloid ☐ Absorptive ☐ None ☐ Other: _____
4. If other therapies were considered and ruled out, what conditions prevented you from using other therapies prior to applying V.A.C.® Therapy?:
   ☐ Presence of co-morbidities ☐ High risk of infections ☐ Need for accelerated granulation tissue
   ☐ Prior history of delayed wound healing ☐ Other, please describe: _____
5. Which of the following co-morbidities apply? ☐ Diabetes ☐ Immobility ☐ Immunocompromised ☐ ESRD ☐ PVD ☐ PAD ☐ Obesity ☐ Smoking ☐ Depression ☐ N/A
6. If above diabetes box checked, is the patient on a comprehensive diabetic management program? ☐ Yes ☐ No ☐ N/A
7. Is Osteomyelitis present in Wound? ☐ Yes ☐ No If Yes, please indicate the following:
   ☐ Antibiotic(list name)_____ ☐ IV Antibiotics (list name)_____ ☐ Hyperbaric Oxygen
   Is the above treatment administered to the patient with the intention to completely resolve the underlying bone infection? ☐ Yes ☐ No
8. Please provide a short narrative of possible consequences if Extricare NPWT Pump is not used. (**Please include/attach any clinical data such as H&P, OP report, and other medical documentation supporting treatments tried and describing factors impacting wound healing**): _____

5b Patient's Primary Wound Type

☐ **PRESSURE ULCER:** ☐ Stage III ☐ Stage IV

1. Is the patient being turned/positioned? ☐ Yes ☐ No
2. Has a group 2 or 3 surface been used for ulcer located on the posterior trunk or pelvis? ☐ Yes ☐ No
3. Are moisture and/or incontinence being managed? ☐ Yes ☐ No
4. Is pressure ulcer greater than 30 days? ☐ Yes ☐ No

☐ **DIABETIC ULCER/NEUROPATHIC ULCER:**

1. Has a reduction of pressure on the foot ulcer been accomplished with appropriate modalities? ☐ Yes ☐ No

☐ **VENOUS STASIS ULCER/VENOUS INSUFFICIENCY:**

1. Are compression bandages and/or garments being consistently applied? ☐ Yes ☐ No
2. Is elevation/ambulation being encouraged? ☐ Yes ☐ No

☐ **ARTERIAL ULCER/ARTERIAL INSUFFICIENCY:**

1. Is pressure over the wound being relieved? ☐ Yes ☐ No

☐ **SURGICAL:**

1. Wound surgically created and not represented by descriptions above? ☐ Yes ☐ No
2. Description of surgical procedure._____
3. Date of surgical procedure involving wound._____/ _____/ _____

OTHER WOUND TYPE (describe): _____

Please Complete if Applicable

Is wound a direct result of an accident? ☐ Yes ☐ No
If Yes, complete the following:
Date of accident: ___/ ___/ _____
Accident Type: ☐ Auto ☐ Employment ☐ Trauma

5c Wound(s) Description

Wound #1 Type:_____ Age in Months:_____
Wound Location:_____
Is there eschar tissue present in the wound? ☐ Yes ☐ No
Has debridement been attempted in the last 10 days? ☐ Yes ☐ No
If Yes, debridement date:_____ /_____ /_____
Debridement type: _____
Are serial debridements required? ☐ Yes ☐ No
Measurement date:_____/_____ /_____
Length:_____cm Width:_____cm Depth:_____cm
Appearance of wound bed and color:_____
Exudate (amount and color):_____
Is the wound full thickness? ☐ Yes ☐ No
Is muscle, tendon or bone exposed? ☐ Yes ☐ No
Is there undermining? ☐ Yes ☐ No
Location #1:_____cm, from_____to_____o'clock
Location #2:_____cm, from_____to_____o'clock
Is there tunneling/sinus? ☐ Yes ☐ No
Location #1:_____cm, at_____o'clock
Location #2:_____cm, at_____o'clock

Wound #2 Type:_____ Age in Months: _____
Wound Location: _____
Is there eschar tissue present in the wound? ☐ Yes ☐ No
Has debridement been attempted in the last 10 days? ☐ Yes ☐ No
If Yes, debridement date: ____ / _____/ _____
Debridement type: _____
Are serial debridements required? ☐ Yes ☐ No
Measurement date:_____/ _____/ _____
Length:_____cm Width:_____cm Depth:_____cm
Appearance of wound bed and color:_____
Exudate (amount and color): _____
Is the wound full thickness? ☐ Yes ☐ No
Is muscle, tendon or bone exposed? ☐ Yes ☐ No
Is there undermining? ☐ Yes ☐ No
Location #1:_____cm, from_____to_____o'clock
Location #2:_____cm, from_____to_____o'clock
Is there tunneling/sinus? ☐ Yes ☐ No
Location #1:_____cm, at_____o'clock
Location #2:_____cm, at_____o'clock