Washington State Health Care Authority

Negative Pressure Wound Therapy

Durable Medical Equipment (DME)Program Management Unit
PO Box 45535
Olympia, WA 98504-5535
Fax: 1-866-668-1214

The nursing staff caring for the client must complete all spaces.

All information must be current within 30 days of service dates. You must keep appropriate documentation to substantiate this information in your files.

All current, dated photos of the wound and a copy of the physician's prescription must accompany this form.

Client name		Client ID
Name of nursing facility/nursing service/home health agency	Telephone number	Fax number
RX Physician	Telephone number	Fax number
Service dates		
Estimated length of treatment		

The following complete Wound Therapy Program must be tried and failed prior to negative pressure wound therapy request.

2. a. Evaluation, care and wound measurements;
   b. Application of dressings to maintain a moist wound environment;
   c. Debridement of necrotic tissue, if present;
   d. Evaluation of and provision for adequate nutritional status; and
   e. Standard forms of treatment specific to the type of wounds.

WOUND TYPE

3. List all treatment/dressings tried and failed. Include timeframe for each treatment/dressing.

WOUND EVALUATION: (Must be current stage, not "healing stage")

4.	A.	B.	C.
Location			
Size (width and length)			
Depth			
Stage			
Tunneling			
Drainage (none, minimum, moderate or heavy			

WOUND TYPE

5a. Surgical? ☐ Yes ☐ No

If yes,

a. Type of surgery:
b. Date of surgery:
c. Date of dehisced:

5b. Pressure? ☐ Yes ☐ No

If yes,

a. Support surface in use? ☐ Yes ☐ No
   i. If yes, what kind/name?
b. Moisture/Incontinence managed? ☐ Yes ☐ No

5c. Neuropathic (diabetic) ulcer? ☐ Yes ☐ No

If yes,

a. Patient on a comprehensive diabetic management program? ☐ Yes ☐ No
b. Reduction of pressure on a foot ulcer was accomplished with off loading ☐ Yes ☐ No

5d. Venous stasis ulcer? ☐ Yes ☐ No

If yes,

a. Compression bandages/garments consistently applied? ☐ Yes ☐ No
b. Is leg(s) elevated? ☐ Yes ☐ No
c. Is client ambulating? ☐ Yes ☐ No

CONTRAINDICATIONS (FDA SAFETY COMMUNICATION)

1. Is wound clean and free of necrotic tissue/eschar? ☐ Yes ☐ No
   If no, why?

2. Is untreated osteomyelitis present within the vicinity of the wound? ☐ Yes ☐ No
3. Is cancer present in the wound? ☐ Yes ☐ No
4. Is there a fistula to an organ or body cavity within the vicinity of the wound? ☐ Yes ☐ No
5. Exposed vascularature ☐ Yes ☐ No
6. Exposed nerves ☐ Yes ☐ No
7. Exposed anastomotic site ☐ Yes ☐ No
8. Exposed organs ☐ Yes ☐ No

LABS

Date drawn:

1. Albumin; Pre	2. Hematocrit:	3. Hemoglobin:	4. If diabetic, need HgbA1C:

Attach medical/clinical notes from last two visits and two wound care notes, including all medical conditions. Last two visits notes may be from hospital nursing/physician notes. Include colored wound photos. Photos must include measurement tool demonstrating wound size.

Nursing staff signature	Date

Title