



Memorial Hermann Health System
Home Health Negative Pressure Wound Therapy Orders

Please send both pages to Memorial Hermann Home Health
Phone: 281-784-7550 Fax: 281-784-7545
Email: HomeHealthNPWTIntake@MemorialHermann.org

PATIENT DELIVERY INFORMATION

Requested Delivery Date: Requested Delivery Time:

Patient Name: Patient DOB:

Address: City: State: ZIP:

Patient Cell Phone:

Hospital Delivery: Deliver to Hospital Utilizing Consignment Pump - No Delivery Needed

Hospital/Facility Name:

Room Number: Direct Phone Number to Patient's Room:

Anticipated Hospital/Facility Discharge Date: (if applicable) *

* Medicare allows delivery to a hospital/facility up to 48 hours prior to anticipated discharge for the purpose of fitting and training.

Home Delivery: Deliver to Patient's Home? Yes No Same Address as Listed on Form

OR

Deliver to Alternate Address

Alternate Address: City: State: ZIP:

PATIENT FOLLOW-UP CARE

Name of Home Health Agency Following the Patient:

Phone: Fax:

Name of Wound Care Clinic Following the Patient: (if applicable)

Phone: Fax:

REQUIRED DOCUMENTATION CHECKLIST

PLEASE ATTACH THE FOLLOWING:

- Face Sheet Pre-Op Report Current Wound Notes
Physician Face-to-Face Notes Post-Op Report Prior Treatments (if chronic wound)

Referral Name & Title: _____ Referral Location: _____

Order Date: _____ Phone: _____ Fax: _____

Patient Name: _____ DOB: _____

Patient Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Mobile: _____ Email: _____

Insurance Provider: _____ Insurance ID#: _____

Secondary Insurance: _____ Insurance ID#: _____

Diagnosis Code(s) ICD-10: _____

I prescribe a Negative Pressure Wound Therapy Pump, and up to 15 Wound Care Sets/Dressing Kits per wound per month and 10 Canister Sets per month. Number of Months: 1 Month 2 Months 3 Months 4 Months Other: _____
Pressure Setting: 100 mmhg 120 mmhg 140 mmhg
 Other: _____ Frequency of Dressing Changes _____

OR Alternatively I prescribe the Negative Pressure Wound Therapy Pump and up to _____ Dressing Kits (quantity) per wound per month, and _____ Canister Sets (quantity) per month.

SUPPLIES FOR DELIVERY (Please check ONE box for Foam or Gauze, and check ONE box for Size)

Dressing Kit: Black Foam Gauze Size: Small Medium Large Other Supplies: _____
(Y-Connectors, White Foam, etc.)

CURRENT WOUND MEASUREMENTS

Wound Location: (Please attach additional information if more than one wound present)

#1: _____ Age: _____ Measurement Date: _____ Necrotic tissue present? YES NO

Length: _____ Width: _____ Depth: _____

Tunneling: YES NO Location: From _____ o'clock to _____ o'clock

Undermining: YES NO Location: From _____ o'clock to _____ o'clock

#2: _____ Age: _____ Measurement Date: _____ Necrotic tissue present? YES NO

Length: _____ Width: _____ Depth: _____

Tunneling: YES NO Location: From _____ o'clock to _____ o'clock

Undermining: YES NO Location: From _____ o'clock to _____ o'clock

Wound History: Was NPWT initiated in an inpatient facility? YES NO Date: _____

Is there anything compromising the patient's nutritional status? YES* NO *If YES, what measures have been taken?

Is the patient on a comprehensive diabetic management program? YES NO N/A

Is NPWT being ordered for any type of chronic wound (30 days or more)? YES* NO *If YES, which previous wound treatments have been applied to maintain a moist wound environment to promote healing?

For Stage 3 & 4 Pressure Ulcers: Is the patient using a group 2 or 3 support surface? YES NO

Is patient on a turning schedule? YES NO Is moisture and incontinence being managed? YES NO

For Diabetic and or Neuropathic Ulcers: Is pressure on the foot being reduced with proper modalities? YES NO N/A

By signing and dating, I attest that I am prescribing Negative Pressure Wound Therapy as medically necessary and all other applicable treatments have been tried or considered and ruled out. I have read and understand all safety information and other instructions for use included with therapy clinical guidelines. Additionally, I have reviewed the information provided in this form and attest to its accuracy.

Prescription must be manually signed and faxed to: Memorial Hermann Durable Medical Equipment Order Form, Fax: 281-784-7545

Signature Physician Print Name NPI/MHHS ID. Date Time AM PM Contact No.

Address City State Zip

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