MEMORIAL HERMANN Home Care

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)*

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Home Health Negative Pressure Wound Therapy Orders

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 ☐ 120 ☐ 140 ☐ 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: ☐ Foam ☐ Gauze Size: ☐ Small ☐ Medium ☐ Large ☐ Other Supplies: _____

(Y-Connectors, Gauze Rolls, 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

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.

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

Address	City	State	Zip