ROTECH HEALTHCARE INC.

NEGATIVE PRESSURE WOUND THERAPY – FAX COVER

QUESTIONS? Call Our NPWT Customer Service Team Directly: 844-592-5068

FAX REFERRAL INFORMATION TO ROTECH'S NPWT DEPARTMENT: 866-233-7102

PATIENT DELIVERY INFORMATION

Requested Delivery Date: _____ Requested Delivery Time: _____

Hospital Delivery:

☐ **NPWT Pump & Starter Kit On Hand at Facility** ***OR*** ☐ **NPWT Pump & Starter Kit Needed**

Hospital/Facility Name: _____

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

Patient Cell Phone: _____

Address: _____ City/State/ZIP: _____

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:

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

OR

☐ Delivery 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: _____

ROTECH HEALTHCARE INC. NEGATIVE PRESSURE WOUND THERAPY – ORDER FORM

QUESTIONS? Call Our NPWT Customer Service Team Directly: 844-592-5068

PLEASE SIGN AND FAX TO ROTECH'S NPWT DEPARTMENT: 866-233-7102

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#: _____

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 ☐ 130 ☐ 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 (>30days 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.

PHYSICIAN NAME: _____ **NPI#:** _____

PHONE: _____ **FAX:** _____

ADDRESS: _____ **CITY/ST/ZIP:** _____

PHYSICIAN SIGNATURE: _____ **DATE:** _____