Fax Transmittal Form
Negative Pressure Wound Therapy

To: Bedard Medical Supplies

Phone: 207-784-3700

Fax: 207-784-7992

Re:_____

From: _____

Phone:_____ Ext # _____

Fax:_____

Please Include the Following Documentation Necessary for NPWT Orders:

- ☐ Patient demographic sheet
- ☐ Medela Negative Pressure Wound Therapy Authorization Order Form (attached)
  - 1 form required *per* wound. Entire form must be filled out and signed by a PECOS registered clinician.
- ☐ Wound documentation from medical record
- ☐ History and physical, operative reports and progress reports
- ☐ Diabetic and nutritional status

Delivery Information

Delivery Date:_____ Delivery Time:_____

Delivery Address:

☐ Patient's Home ☐ Referring Facility ☐ Other:_____

Date Sent: _____ Time Sent: _____ # of Pages Including Cover Page: _____

bedard MEDICAL SUPPLIES

Medela Negative Pressure Wound Therapy Authorization Order Form

Phone: 207-784-3700

Please fax this form to Bedard Medical Supplies at 207-784-7992

*For therapy on multiple wounds, please complete an order form *per* wound.*

1. Patient Information

Patient Name:_____ DOB:_____

Address:_____ Phone #:_____

Emergency Contact:_____ Relationship:_____ Phone #:_____

Primary Insurance:_____ Policy #:_____

2nd Insurance:_____ Policy #:_____

Home Health Agency:_____ Phone #:_____

2. Clinical Wound Information

Was NPWT utilized within the last 90 days? ☐ YES ☐ NO
*If YES, date initiated:*_____

Is the patient's nutritional status compromised? ☐ YES ☐ NO
*If YES, please attach nutritional plan. Albumin Level:*_____

Is osteomyelitis present in the wound? ☐ YES ☐ NO
*If YES, treated with:*_____

Is malignancy present in the wound? ☐ YES ☐ NO

Is there an open fistula to an organ or body cavity within the vicinity of the wound? ☐ YES ☐ NO

Which therapies were utilized to maintain a moist wound environment?

☐ Saline/Gauze ☐ Hydrogel ☐ Alginate ☐ Hydrocolloid
☐ Absorptive ☐ Other:_____

Wound location:_____ Wound Age:_____

Is wound full thickness? ☐ YES ☐ NO

Length:_____cm **Width**:_____cm **Depth**:_____cm

Measurement Date:_____

Exudate Amount (daily):_____

Is exudate amount greater than 90 ml/day? ☐ **YES** ☐ **NO**
If YES, the 800 ml canister must be prescribed

Exudate Type:_____ **Odor:** ☐ **YES** ☐ **NO**

Please check what is exposed:
☐ Muscle ☐ Tendon ☐ Bone ☐ None

Is there tunneling? ☐ YES ☐ NO
If YES, Location #1 _____ *cm, @*_____ *o'clock*
Location #2 _____ *cm, @*_____ *o'clock*

Is there undermining? ☐ YES ☐ NO
If YES, Location #1 _____ *cm, @*_____ *o'clock*
Location #2 _____ *cm, @*_____ *o'clock*

Has a debridement been performed in the past 10 days? ☐ YES ☐ NO

If YES, Debridement Date:_____ **Debridement Type:**_____
*Debridement needs to be attempted for the presence of necrotic tissue

Wound Bed Appearance *(Must total 100%)*:
Granulation/Clean Tissue _____% Slough _____% Necrotic _____%

3. Wound Type

☐ **Pressure Ulcer:** ☐ Stage III ☐ Stage IV
Is patient being turned/positioned? ☐ YES ☐ NO
Has a group 2 or 3 surface been used for ulcer located on the posterior trunk or pelvis? ☐ YES ☐ NO
Are moisture and/or incontinence being managed? ☐ YES ☐ NO
Is pressure ulcer greater than 30 days? ☐ YES ☐ NO

☐ **Diabetic Ulcer/Neuropathic Ulcer:**
Has a reduction of pressure on the foot ulcer been accomplished with appropriate modalities? ☐ YES ☐ NO

☐ **Venous Stasis Ulcer/Venous Insufficiency:**
Are compression bandages and/or garments being consistently applied? ☐ YES ☐ NO
Is elevation/ambulation being encouraged? ☐ YES ☐ NO

☐ **Arterial Ulcer/Arterial Insufficiency:**
Is pressure over the wound being relieved? ☐ YES ☐ NO

☐ **Surgical:**
Wound surgically created and not represented by descriptions above? ☐ YES ☐ NO
Description of surgical procedure:_____
Date of surgical procedure involving wound: _____

☐ **Chronic Ulcer of Mixed Etiology** (describe):_____
☐ **Other Wound Type** (describe):_____

4. Physician's Order

Face-to-Face Date:_____

I prescribe the Medela NPWT:

☐ Liberty (300 or 800 ml)
☐ Motion (150 ml only)

Pressure Setting:_____ ☐ Continuously ☐ Intermittently

For the following wound type: ☐ Surgical ☐ Dehisced ☐ Traumatic
☐ Pressure Ulcer ☐ Venous/Arterial Ulcer
☐ Neuropathic/Diabetic Ulcer ☐ Chronic Mixed Etiology (≥ 30 Days)

Wound Location:_____ **Therapy Start Date:**_____

Goal of NPWT: ☐ Assist granulation tissue formation
☐ Delayed Primary Closure ☐ Flap/Graft

Length of Need (Anticipated): ☐ **1 Month** ☐ **2 Months** ☐ **3 Months**
☐ **4 Months** (Medicare allows 4 months with wound improvement) ☐ **Other:**_____

I prescribe up to **15 dressing kits** and up to **10 canisters** per month/per wound:
(Please select size/style):

Medela Kits		
Foam:	☐ Small 10 x 8 x 3 cm	☐ Medium 19 x 12.5 x 3 cm ☐ Large 25 x 15 x 3 cm
White Foam:	☐ Small 10 x 7.5 x 1 cm	☐ Medium 15 x 10 x 1 cm
Gauze:	☐ Medium 17 x 16 cm squares	☐ Large 370 x 11.4 cm roll

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Canisters:	☐ 300 ml (Liberty Only) ☐ 800 ml (Liberty Only) ☐ 150 ml (Motion Only)
	☐ Y-connector (multiple wounds)
	☐ Silverlon Contact Layer

5. Diagnosis Information

ICD-10 Code	Description

6. Prescriber Information

Original Signature Required. No Stamps

Prescriber Name:_____

Prescriber Signature:_____

NPI #:_____ Date:_____

Phone #:_____

By signing and dating, I attest that I am prescribing the Medela NPWT Pumps 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 instruction for use included with the Medela product. I also understand the Medela NPWT contraindications: patients with malignancy in the wound, untreated osteomyelitis, nonenteric and unexplored fistulas, necrotic tissue and eschar present. Foam dressing for this system should not be placed directly in contact with exposed blood vessels, anastomotic sites, organs, or nerves. The Durable Medical Equipment Medicare Administrative Contractors (DME MACs) state that beyond the first four months of therapy, "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 the medical need.

Additional Notes: