Who should we contact for questions regarding this order?
Contact Name: _____

Direct Phone: _____ Fax: _____

PATIENT INFORMATION			
Patient's Name (Last, First, MI):			☐ Male ☐ Female
Patient's DOB: _____/_____/_____	Social Security #: ___ ___ ___ - ___ ___ - ___ ___ ___ ___		Cell Phone:
Infectious Disease: ☐ No ☐ Yes ⇨ If Yes: What? _____			
Patient's Permanent Address:			
City:	State:	Zip:	Phone:

INSURANCE INFORMATION			
Is the financial obligation for the patient's NPWT the responsibility of a party other than the patient's insurance (i.e., workman's comp, Litigation, etc.)? ☐ No ☐ Yes ⇨ If Yes: Name of responsible party: _____ Contact Phone: _____			
PRIMARY INSURANCE: ☐ Medicare ☐ Private Insurance ☐ Medicaid ☐ Molina			Group #:
Insurance Name:			Policy/ID #:
SECONDARY INSURANCE: ☐ Medicare ☐ Private Insurance ☐ Medicaid ☐ Molina			Group #:
Insurance Name:			Policy/ID #:
TERTIARY INSURANCE: Insurance Name:			
Group #:	Policy/ID #:		Phone:
Primary Care Physician **if not** Prescriber:			Phone:

CLINICAL CARE PROVIDER INFORMATION [The organization that will be providing the patient's wound care]		
Name of Organization:		
Address:		
City:	State:	Zip:
Organization Phone:	Organization Fax:	
Organization Contact:	Direct Phone:	

PLEASE FAX DOCUMENTS TO GALAXY MEDICAL PRODUCTS, INC AT 330-665-4199

Patient Name: **DOB:** _____/ _____/ _____

★ **Please include copies of all pertinent information from patient's medical record to validate the information provided here.** ★

WOUND TYPE

★ [Check only one wound type below. Complete a separate Secondary Wound Assessment Form for **each** additional wound.] ★

☐ **1. SURGICALLY CREATED or DEHISCED WOUND**		
☐ **2. TRAUMATIC WOUND**		
☐ **3. PRESSURE ULCER:** ☐ **Stage III** ☐ **Stage IV** ⇨	**A)** Is the patient being appropriately turned/positioned? **B)** If patient's pressure ulcer is on the posterior trunk or pelvis, has a group 2 or 3 support surface been used? Make:_____ Model: _____ **C)** Is moisture/incontinence being managed?	☐ Yes ☐ No ☐ Yes ☐ No ☐ N/A ☐ Yes ☐ No
☐ **4. VENOUS/ARTERIAL ULCER** ⇨	**A)** Are compression bandages and/or garments being consistently applied? **B)** Is leg elevation/ambulation being encouraged?	☐ Yes ☐ No ☐ Yes ☐ No
☐ **5. NEUROPATHIC ULCER (i.e., diabetic ulcer)** ⇨	Has pressure on the foot ulcer been reduced with appropriate modalities?	☐ Yes ☐ No
☐ **6. CHRONIC ULCER/MIXED ETIOLOGY (present at least 30 days)** ⇨	**A)** Is pressure over the wound being relieved? **B)** Is moisture/incontinence being managed?	☐ Yes ☐ No ☐ N/A ☐ Yes ☐ No

WOUND HISTORY

1) Which therapies have been previously utilized to maintain a moist wound environment? [Check all that apply.]

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

2) Is the patient's nutritional status compromised? ☐ No ☐ Yes ⇨ If Yes, check the actions taken:

☐ Protein Supplements ☐ Enteral/NG Feeding ☐ TPN ☐ Vitamin Therapy ☐ Other: _____

3) Was NPWT utilized within the last 60 days? ☐ No ☐ Yes ⇨ If Yes: ☐ Inpatient ☐ Outpatient

If Yes, Date initiated: _____/_____/_____ Facility Name: _____

4) Does patient have diabetes? ☐ No ☐ Yes ⇨ If Yes, is patient on a comprehensive diabetic management program? ☐ No ☐ Yes

5) Is there osteomyelitis present in the wound? ☐ No ☐ Yes ⇨ If Yes, treated with: _____

6) If wound is > 90 days, has a biopsy been done? ☐ No ☐ Yes*
*If Yes, is cancer in the wound? ☐ No ☐ Yes ⇨ (contraindicated)

7) Is there a fistula to an organ or body cavity within vicinity of the wound? ☐ No ☐ Yes*
*If Yes: ☐ Enteric ☐ Non-Enteric ⇨(contraindicated)

8) Date of last debridement: _____/_____/_____ **REQUIRED**
Type of Debridement:: ☐ Mechanical ☐ Chemical ☐ Surgical

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★ **Please include copies of all pertinent information from patient's medical record to validate the information provided here.** ★

TO BE COMPLETED BY PRESCRIBER

PRESCRIPTION, ATTESTATION AND PRESCRIBER INFORMATION

Patient Name [print] (last, first, mi)_____ DOB: _____/_____/_____

I prescribe Invia® Wound Therapy. This includes: an Invia® Wound Therapy suction pump, up to 15 wound dressing kits/per Wound/per month and up to 10 canisters per month. The **anticipated length of therapy is _____ month(s)** to begin on or around _____/_____/_____ for the following diagnosis **(ICD-9-CM diagnosis code specific to 4th or 5th digit or narrative):**

★ **Primary DX: _____** Secondary DX:_____ Tertiary DX:_____ ★

Goal at the completion of Invia® Wound Therapy: ☐ **Assist Granulation Tissue Formation** ☐ **Delayed Primary Closure (Tertiary)**

☐ **Gauze Dressing OR** ☐ **Foam Dressing** is to be changed: _____ times per week with suction set at _____**mmHg**

Prescriber's Signature: _____ Date: _____/_____/_____
(No stamps please)

Prescriber's Name **[print]** (last)	(first)	(mi)

Address:	City:	State:	Zip:

Phone:	Fax:	NPI:

WOUND MEASUREMENTS ★ **Complete a separate Secondary Wound Assessment Form for <u>each</u> additional wound.** ★

Location of Wound:	**Wound Age in Months:**

What was the original cause of this wound:
☐ Revision ☐ Attempt to close ☐ Debridement ☐ Dehiscence ☐ Surgical Graft ☐ Infection ☐ I & D
☐ Other _____

Presence of necrotic tissue with eschar? ☐ No ☐ Yes* [Please obtain measurements after debridement.]
*If yes, type of debridement: ☐ Mechanical ☐ Chemical ☐ Sharp/Surgical ⇨ If Sharp/Surgical, date: _____/_____/_____

Length: _____cm Width: _____cm Depth*: _____cm *If depth is less than or equal to 0.5 cm, please provide documentation whether underlying structures (such as bone, muscle, fascia) are exposed	Measurement Date: _____/_____/_____

Is there Undermining? ☐ No ☐ Yes* * If Yes, complete details below. Location #1: _____cm, from _____to _____ o'clock Location #2: _____cm, from _____to _____ o'clock	Is there tunneling/sinus? ☐ No ☐ Yes* *If Yes, complete details below. Location #1: _____cm, @ _____ o'clock Location #2: _____cm, @ _____ o'clock

Exudate Type: ☐ Serous ☐ Serosanguinous ☐ Other _____
Exudate Amount: ☐ < 100 ml/day ☐ > 100 ml/day

PRODUCTS PROVIDED

Upon establishment of medical necessity, Galaxy Medical will schedule delivery of an Invia® Wound Therapy pump, 15 wound dressing kits per wound per month and 10 canisters per month. If you would like to make a special request for other/additional supplies, please check here ☐ and a client services representative will contact you regarding this. [Please allow **<u>at least 48 hours</u>** following review of completed form.]