APRIA®

Initiation of Negative Pressure Wound Therapy Form

Fax completed form to: _____

Apria Representative _____ **Branch Location** _____ **Phone** _____

REFERRAL SOURCE

Facility name _____ Contact name _____

Order date _____ Delivery date _____ Phone _____ Fax _____

PATIENT INFORMATION

Patient name _____ **PLEASE SEND PATIENT DEMOGRAPHICS, CHART NOTES AND INSURANCE INFORMATION** DOB _____ Email _____

The prescriber MUST clearly document in the patient's medical records that other therapies have been tried or considered and ruled out prior to the application of NPWT. Patient chart notes MUST include documentation of (i) wound location, and (ii) wound measurements, including date measurements were taken and unit of measure in Length x Width x Depth format.

THERAPY INCLUDES THE FOLLOWING:

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 _____ **Frequency of dressing changes** _____

Diagnosis Code ICD-10 Write in complete code(s):

_____

SUPPLIES FOR DELIVERY (Note: Foam kits do not include scissors)

Foam Dressing Kit: ☐ S ☐ M ☐ L **White Foam:** ☐ S ☐ L **Gauze Dressing Kit:** ☐ S ☐ L ☐ Other _____

Type of pump or equivalent: ☐ Medela Invia® Liberty™ ☐ Medela Invia® Motion™-Endure ☐ Other _____

No substitutions allowed _____ Other specifications: _____

Information above provided by: (non-Apria employee) _____ FIRST NAME _____ LAST NAME **Employer of person providing information:** _____

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.

Print prescriber's name _____ **Prescriber email** _____ **NPI #** _____

Prescriber's signature _____ **Date** _____

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