Invia® Wound Therapy

Discharge Form

PATIENT INFORMATION	
Patient's Name (last, first, MI):	
Patient's DOB: _____/_____/_____ (mm/dd/yyyy)	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___

PHYSICIAN'S GOAL FOR THERAPY
Was the Physician's goal for therapy met? ☐ Yes ☐ No*
*If No, why not?_____
_____

DISCHARGE ASSESSMENT [Indicate when Invia® Wound Therapy has been discontinued and the outcome.]				
Therapy Discharge Date: _____/_____/_____ (mm/dd/yyyy)				
Wound #1				
Wound Location:				
Wound Status (Check all that apply.)				
☐ Adequate granulation	☐ Patient in hospital	☐ Wound unresponsive	☐ Pain	
☐ Wound healed	☐ Delayed primary closure	☐ Patient non-compliant	☐ Patient expired	
☐ Wound sutured closed	☐ Tunnel dimensions decreased or closed	☐ Undermining improved or resolved		
☐ 4 months of treatment completed	☐ Other (please describe)			
Final wound measurements Date:_____/_____/_____ (mm/dd/yyyy)	Length: cm	Width: cm	Depth: cm	

Wound #2 [Complete **only** if a second wound was treated.]				
Wound Location:				
Wound Status (Check all that apply.)				
☐ Adequate granulation	☐ Patient in hospital	☐ Wound unresponsive	☐ Pain	
☐ Wound healed	☐ Delayed primary closure	☐ Patient non-compliant	☐ Patient expired	
☐ Wound sutured closed	☐ Tunnel dimensions decreased or closed			
☐ 4 months of treatment completed	☐ Other (please describe)			
Final wound measurements Date:_____/_____/_____ (mm/dd/yyyy)	Length: cm	Width: cm	Depth: cm	

Print name title and employer of individual providing information:	
Phone:	Date: _____/_____/_____ (mm/dd/yyyy)

Thank you for completing this form.

For DME Use Only:	Information taken verbally by _____ (**DME** employee) from _____ (caregiver) on _____/_____/_____ (Date: mm/dd/yyyy) at _____ (time).

Please fax documents to your DME provider

Invia® Wound Therapy

Secondary Wound Assessment Form

Use this form for each additional wound requiring treatment with Invia® Wound Therapy.

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

PATIENT INFORMATION

Patient's Name (last, first, MI):

Patient's DOB: _____/_____/_____ (mm/dd/yyyy) | SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___

WOUND TYPE & HISTORY [Check only 1 wound type below. Complete 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? ☐ Yes ☐ No
B) If patient's pressure ulcer is on the posterior trunk or pelvis, has a group 2 or 3 support surface been used? ☐ Yes ☐ No ☐ N/A
C) Is moisture/incontinence being managed? ☐ Yes ☐ No

☐ **4. VENOUS/ARTERIAL INSUFFICIENCY ULCER:**
A) Are compression bandages and/or garments being consistently applied? ☐ Yes ☐ No
B) Is leg elevation/ambulation being encouraged? ☐ Yes ☐ No

☐ **5. NEUROPATHIC ULCER (e.g., diabetic ulcer):**
A) 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? ☐ Yes ☐ No ☐ N/A
B) Is moisture/incontinence being managed? ☐ Yes ☐ No

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 there osteomyelitis present in the wound? ☐ No ☐ Yes ⇨ If Yes, treated with: _____
3) If wound is > 90 days, has a biopsy been done? ☐ No ☐ Yes ⇨ If Yes, is cancer in the wound? ☐ No ☐ Yes ⇨ (contraindicated)
4) Is there a fistula to an organ or body cavity within vicinity of the wound? ☐ No ☐ Yes ⇨ If Yes: ☐ Enteric ☐ Non-enteric ⇨ (contraindicated)

WOUND MEASUREMENTS [Complete separate Secondary Wound Assessment Form for each additional wound.]

Wound Location: | Wound Age in Months:

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: _____/_____/_____ (mm/dd/yyyy)

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: _____/_____/_____ (mm/dd/yyyy)

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 ☐ Serosanginous ☐ Other _____ | Exudate Amount: ☐ < 100 ml/day ☐ > 100 ml/day

PRESCRIPTION, ATTESTATION & PRESCRIBER INFORMATION [Complete ONLY if patient is ALREADY undergoing treatment on Invia®.]

Patient Name [print] (last) _____ (first) _____ (mi) _____
I prescribe Invia® Wound Therapy. This includes up to 15 wound dressing sets/per wound/per month. The anticipated length of therapy is _____ month(s) starting on _____/_____/_____ (mm/dd/yyyy) for the following diagnosis (ICD-9-CM diagnosis code specific to 4th or 5th digit or narrative): _____

Prescriber's Signature _____ Date _____/_____/_____ (mm/dd/yyyy)

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

Address: | City: | State: | Zip:

Phone: | Fax: | NPI:

Goal at the completion of Invia® Wound Therapy: ☐ Assist granulation tissue formation ☐ Delayed primary closure (tertiary)

PRODUCTS PROVIDED

Upon establishment of medical necessity, your DME will ship 15 wound dressing sets per month per wound. If you would like to make a special request for other supplies, please check here ☐ and a customer service representative will contact you regarding this.

Requested delivery date: _____/_____/_____ (mm/dd/yyyy) [Please allow **at least 24 hours** following review of completed form.]

Please fax documents to your DME provider

Invia® Wound Therapy

Monthly Wound Assessment Form

Please complete a separate Monthly Wound Assessment Form for EACH WOUND currently being treated with Invia® Wound Therapy.
Please include copies of all pertinent information from patient's medical record to validate the information provided here.

PATIENT INFORMATION

Patient's Name (last, first, MI):

Patient's DOB: _____/_____/_____ (mm/dd/yyyy) | SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___

1) Has the clinical care provider for this patient changed in the last 30 days? ☐ No ☐ Yes

If Yes, Name of Organization:

Address:

City: | State: | Zip:

Organization Phone: | Organization Fax:

Organization Contact Name: | Contact Direct Phone:

2) Has the patient been on Invia® Wound Therapy for less than 30 days? ☐ No ☐ Yes ⇨ If Yes, Placement Date: _____/_____/_____ (mm/dd/yyyy)

Placement measurements ⇨ Length:_____ cm Width:_____ cm Depth:_____ cm

3) Was the patient admitted to a hospital or SNF within the last 30 days? ☐ No ☐ Yes

If Yes, date admitted: _____/_____/_____ (mm/dd/yyyy) Date discharged: _____/_____/_____ (mm/dd/yyyy)

Name of facility: _____ Facility phone: _____

Was the patient using the NPWT during this inpatient stay? ☐ No ☐ Yes

4) Was NPWT suspended at any time during the last 30 days? ☐ No ☐ Yes

If Yes, date suspended:_____/_____/_____ (mm/dd/yyyy) Date restarted:_____/_____/_____ (mm/dd/yyyy)

5) Is patient continuing treatment on NPWT? ☐ No ⇨ Discharge Form ☐ Yes ⇨ Continue below

WOUND STATUS [Complete this section at least 7 days prior to next treatment cycle.]

1) Has the wound been debrided in the last 30 days? ☐ No ☐ Yes ⇨ If Yes: ☐ Mechanical ☐ Chemical ☐ Surgical

If Surgical, date of debridement: _____/_____/_____ (mm/dd/yyyy) (Ensure measurements below are <u>after</u> most recent debridement.)

2) Wound Location:_____ Measurement Date: _____/_____/_____ (mm/dd/yyyy)

Wound measurements 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.

a. Sinus/Tunnel #1: _____cm @ _____o'clock. Undermining #1:_____cm @ _____ to _____o'clock.

Sinus/Tunnel #2: _____cm @ _____o'clock. Undermining #2:_____cm @ _____ to _____o'clock.

b.

Wound bed color	☐ beefy red	☐ pale pink	☐ gray	Wound margins	☐ decreased	☐ no change	☐ increased
Granulation tissue	☐ increased	☐ no change		Exudate amount	☐ decreased	☐ no change	☐ increased
Wound odor	☐ decreased	☐ no change	☐ new	Exudate color	☐ clear	☐ pink	☐ bloody
					☐ other _____		

4) Has the standard supply of 15 wound dressing sets per wound per month and 10 canisters per month been adequate for this patient?
☐ No ☐ Yes ⇨ If No, your equipment and supply provider will contact you regarding this.

_____ _____
Licensed clinician's printed name, title | Phone

_____ _____/_____/_____ _____
Signature | Date: mm dd yyyy | Fax

For DME Use Only:

Information taken verbally by _____ (DME employee) from _____ (caregiver) on _____/_____/_____ (Date: mm dd yyyy) at _____ (time).

Please fax documents to your DME provider

Invia® Wound Therapy

Request for Additional Supplies

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

PATIENT INFORMATION [Complete this section ONLY if you will not be supplying a Face Sheet that contains this information.]	
Patient's Name (Last, First, MI):	
Patient's DOB: _____/_____/_____ (mm/dd/yyyy)	SS# ____ ____ ____ - ____ ____ - ____ ____ ____ ____

JUSTIFICATION FOR ADDITIONAL SUPPLIES

- ☐ Wound size exceeds the largest available dressing set
- ☐ Dressing changes are required more often than 48-hours (please explain below)
- ☐ Wound is heavily draining beyond capacity of largest canister in a 3-day period
- ☐ Other (please explain in detail) _____

Due to the above, please have a customer service representative contact me regarding additional supplies:

Contact Name: _____

Title: _____

Phone Number: _____

Alternate Phone Number: _____

TO BE COMPLETED BY PRESCRIBER

PRESCRIPTION, ATTESTATION AND PRESCRIBER INFORMATION

I attest that Patient, _____, needs additional supplies (beyond the initially supplied 15 dressing sets and 10 canisters per month) for the proper administration of negative pressure wound therapy with Invia® Wound Therapy. This request is being made for the reasons defined above:

Prescriber's Signature _____ Date _____/_____/_____ (mm/dd/yyyy)

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

Address:	City:	State:	Zip:

Phone:	Fax:	NPI:

Please fax documents to your DME provider

Invia® Wound Therapy

NPWT Order Form

Who should we contact for questions regarding this order?

Contact Name: _____

Direct Phone: _____ Fax: _____

PATIENT INFORMATION [Complete this section ONLY if you will not be supplying a Face Sheet that contains this information.]

Patient's Name (Last, First, MI):			☐ Male ☐ Female
Patient's DOB: _____/_____/_____ (mm/dd/yyyy)	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	Height: _____ (ft., in.)	Weight: _____ (lbs.)
Patient's Permanent Address:			
City:	State:	Zip:	Phone:

Invia® Wound Therapy will be used in what type of setting: ☐ Private Residence ☐ Assisted Living

Please contact Medela if in: ☐ Skilled Nursing Facility ☐ Rehabilitation Center ☐ Acute Care Facility ☐ LTACH

Delivery Address:		If a facility, Name:	
City:	State:	Zip:	Phone:
Delivery Contact:		Direct Phone:	

INSURANCE INFORMATION [Provide a copy of insurance card(s)]

Is the financial obligation for the patient's NPWT the responsibility of a party other than the patient or 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	Group #:
Insurance Name:	Policy/ID #:
Insurance Address:	Phone:
Primary Care Physician **if not** Prescriber:	Phone:
SECONDARY INSURANCE: ☐ Medicare ☐ Private Insurance ☐ Medicaid	Group #:
Insurance Name:	Policy/ID #:
Insurance Address:	Phone:
TERTIARY INSURANCE: Insurance Name:	

Group #:	Policy/ID #:	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 Name:	Direct Phone:	

Please fax documents to your DME provider

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? ☐ Yes ☐ No B) If patient's pressure ulcer is on the posterior trunk or pelvis, has a group 2 or 3 support surface been used? ☐ Yes ☐ No ☐ N/A C) Is moisture/incontinence being managed? ☐ Yes ☐ No
☐ **4. VENOUS/ARTERIAL ULCER** ⇨	A) Are compression bandages and/or garments being consistently applied? ☐ Yes ☐ No B) Is leg elevation/ambulation being encouraged? ☐ Yes ☐ No
☐ **5. NEUROPATHIC ULCER (e.g., diabetic ulcer)** ⇨	A) 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? ☐ Yes ☐ No ☐ N/A B) Is moisture/incontinence being managed? ☐ 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 90 days? ☐ No ☐ Yes ⇨ If Yes: ☐ Inpatient ☐ Outpatient
   If Yes, Date initiated: _____/_____/_____ (mm/dd/yyyy) 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)

Additional medical documentation may be requested.

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

WOUND MEASUREMENTS

[Complete a separate Secondary Wound Assessment Form for <u>each</u> additional wound.]

Wound Location: | Wound Age in Months:

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: _____/_____/_____ (mm/dd/yyyy)

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: _____/_____/_____ (mm/dd/yyyy)

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 ☐ Serosanginous ☐ Other _____

Exudate Amount: ☐ < 100 ml/day ☐ > 100 ml/day

TO BE COMPLETED BY PRESCRIBER

PRESCRIPTION, ATTESTATION AND PRESCRIBER INFORMATION

Patient Name [print] (last) _____ (first) _____ (mi) _____

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

_____

Goal at the completion of Invia® Wound Therapy: ☐ Assist granulation tissue formation ☐ Delayed primary closure (tertiary)

Prescriber's Signature _____ Date _____/_____/_____ (mm/dd/yyyy)

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

Address: | City: | State: | Zip:

Phone: | Fax: | NPI:

PRODUCTS PROVIDED

Upon establishment of medical necessity, your DME will ship an Invia® Wound Therapy suction pump, 15 wound dressing sets per wound per month and 10 canisters per month. If you would like to make a special request for other supplies, please check here ☐ and a customer service representative will contact you regarding this.

Requested delivery date: _____/_____/_____ (mm/dd/yyyy) [Please allow **<u>at least 24 hours</u>** following review of completed form.]