



For Customer Service, call:-  
1-800-208-2025

Please FAX completed forms to:-  
1-877-487-7878

**CERTIFICATE OF MEDICAL NECESSITY**

Patient Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**PATIENT'S WOUND HISTORY**

- Will the NPWT be used in a  Nursing Home/ Rehab  Private Resident  LTAC  ALF  Other \_\_\_\_\_  
Name of Facility: \_\_\_\_\_ Phone: \_\_\_\_\_ Date NPWT was initiated: \_\_/\_\_/\_\_
- Is there anything compromising the patient's nutritional status?  Yes  No  
If yes, what measures have been taken?  Protein Supplements  Enteral/NG Feeding  TPN  Vitamin Therapy  Special Diet  
 Other \_\_\_\_\_
- Is the patient's wound a direct result of an accident?  Yes  No Date of accident: \_\_/\_\_/\_\_  
Accident Type:  Auto  Employment  Trauma  Responsible Party: \_\_\_\_\_

**ADDITIONAL INFORMATION BY WOUND TYPE (CHECK ONLY ONE)**

- Pressure Ulcer:  Stage III  Stage IV**  
Is moisture/incontinence being managed?  Yes  No  N/A  
Was Group 2 or 3 support surface used for ulcers on the posterior pelvis or trunk prior to and during NPWT?  Yes  No  N/A  
Is the patient being turned and positioned?  Yes  No  N/A
- Diabetic and/or Neuropathic Ulcer/ Arterial Ulcer or Arterial insufficiency**  
Is the patient on a comprehensive diabetic management program?  Yes  No  N/A  
Is pressure over wound being relieved?  Yes  No  N/A
- Venous Insufficiency/ Venous Stasis**  
Are compression bandages and/or garments being consistently applied?  Yes  No  N/A  
Is elevation/ambulation being encouraged?  Yes  No  N/A
- Chronic Ulcer of Mixed or Unknown Etiology**  
Thick callus surrounding wound must be debrided prior to NPWT. Was it?  Yes  No  N/A  
Wound must be present for more than 30 days. Was it?  Yes  No  
List previous treatments applied to maintain a moist wound environment without wound responding:  Saline Soaked Gauze  
 Hydrocolloid  Alginate  Hydrogel  Absorptive  Other \_\_\_\_\_
- Traumatic: Describe** \_\_\_\_\_ **Surgical:  Dehiscd  Non-Dehiscd**

**WOUND MEASUREMENTS**

Wound #1 Type: \_\_\_\_\_ Wound Age (mos): \_\_\_\_\_ Measurement date: \_\_\_\_\_ Wound Location: \_\_\_\_\_  
 Is there less than 20% slough/fibrin in the wound?  Yes  No Length: \_\_\_\_\_ cm Width: \_\_\_\_\_ cm Depth: \_\_\_\_\_ cm  
 Was wound debrided recently?  Yes  No Is there undermining?  Yes  No  
 If yes, date: \_\_\_\_\_ Location #1: \_\_\_\_\_ cm, from \_\_\_\_\_ to \_\_\_\_\_ o'clock  
 Are serial debridements required?  Yes  No Location #2: \_\_\_\_\_ cm, from \_\_\_\_\_ to \_\_\_\_\_ o'clock  
 Is muscle, tendon or bone exposed?  Yes  No Is there tunneling/sinus?  Yes  No  
 Does wound has MRSA?  Yes  No Location #1: \_\_\_\_\_ cm, at \_\_\_\_\_ o'clock

**ORGANIZATION PROVIDING THE PATIENTS CLINICAL CARE**

Name of company: \_\_\_\_\_ Phone number: \_\_\_\_\_ Fax: \_\_\_\_\_  
Address: \_\_\_\_\_  
Contact: \_\_\_\_\_

**PRESCRIPTION, ATTESTATION AND PHYSICIAN INFORMATION (Physician must sign & date)**

I prescribe Genadyne NPWT and up to 15 dressing kits, and 5 canister kits per month for \_\_\_ months, starting therapy on \_\_\_ for the following diagnosis: \_\_\_\_\_ ORDER: Cleanse wound with: \_\_\_\_\_  
Change dressing: (how often) \_\_\_\_\_, Setting to be placed at: \_\_\_\_\_ MMHG,  Foam  Gauze.  
Goal at completion of NPWT:  Assist granulation tissue formation  Flap  Graft  Delayed primary closure

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
*By my signature, I attest that I am prescribing Genadyne NPWT (No Substitute) as medically necessary and all other applicable treatments have been tried or considered and ruled out. I have read and understood all safety information and other instructions for NPWT as well as NPWT clinical guidelines.*  
Physician Name: \_\_\_\_\_ MD License \_\_\_\_\_ UPIN \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone \_\_\_\_\_ Fax \_\_\_\_\_ NPI \_\_\_\_\_