

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: ____/____/____ <small>mm dd yyyy</small>	SS# ____-____-____
WOUND TYPE & HISTORY [Check only 1 wound type below. Complete separate Secondary Wound Assessment Form for each additional wound.]	
<input type="checkbox"/> 1. SURGICALLY CREATED OR DEHISCED WOUND	<input type="checkbox"/> 2. TRAUMATIC WOUND
<input type="checkbox"/> 3. PRESSURE ULCER: <input type="checkbox"/> Stage III <input type="checkbox"/> Stage IV A) Is the patient being appropriately turned/positioned? <input type="checkbox"/> Yes <input type="checkbox"/> No B) If patient's pressure ulcer is on the posterior trunk or pelvis, has a group 2 or 3 support service been used? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A C) Is moisture/incontinence being managed? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 4. VENOUS/ARTERIAL INSUFFICIENCY ULCER: A) Are compression bandages and/or garments being consistently applied? <input type="checkbox"/> Yes <input type="checkbox"/> No B) Is leg elevation/ambulation being encouraged? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> 5. NEUROPATHIC ULCER (e.g., diabetic ulcer): A) Has pressure on the foot ulcer been reduced with appropriate modalities? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 6. CHRONIC ULCER/MIXED ETIOLOGY PRESENT AT LEAST 30 DAYS A) Is pressure over the wound being relieved? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A B) Is moisture/incontinence being managed? <input type="checkbox"/> Yes <input type="checkbox"/> No
1) Which therapies have been previously utilized to maintain a moist wound environment? [Check all that apply.] <input type="checkbox"/> Saline/Gauze <input type="checkbox"/> Hydrogel <input type="checkbox"/> Alginate <input type="checkbox"/> Hydrocolloid <input type="checkbox"/> Absorptive <input type="checkbox"/> Other: _____	
2) Is there osteomyelitis present in the wound? <input type="checkbox"/> No <input type="checkbox"/> Yes ⇨ If Yes, treated with: _____	
3) If wound is > 90 days, has a biopsy been done? <input type="checkbox"/> No <input type="checkbox"/> Yes ⇨ If Yes, is cancer in the wound? <input type="checkbox"/> No <input type="checkbox"/> Yes ⇨ (contraindicated)	
4) Is there a fistula to an organ or body cavity within vicinity of the wound? <input type="checkbox"/> No <input type="checkbox"/> Yes ⇨ If Yes: <input type="checkbox"/> Enteric <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes* (Please obtain measurements after debridement.) * If yes, type of debridement: <input type="checkbox"/> Mechanical <input type="checkbox"/> Chemical <input type="checkbox"/> Sharp/Surgical ⇨ If Sharp/Surgical, date: ____/____/____ <small>mm dd yyyy</small>	
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: ____/____/____ <small>mm dd yyyy</small>
Is there undermining? <input type="checkbox"/> No <input type="checkbox"/> Yes ⇨ If Yes, complete details below. Location #1: _____ cm, from _____ to _____ o'clock Location #2: _____ cm, from _____ to _____ o'clock	Is there tunneling/sinus? <input type="checkbox"/> No <input type="checkbox"/> Yes ⇨ If Yes, complete details below. Location #1: _____ cm, @ _____ o'clock Location #2: _____ cm, @ _____ o'clock
Exudate Type: <input type="checkbox"/> Serous <input type="checkbox"/> Serosanguinous <input type="checkbox"/> Other _____	Exudate Amount: <input type="checkbox"/> < 100 ml/day <input type="checkbox"/> > 100 ml/day
PRESCRIPTION, ATTESTATION & PRESCRIBER INFORMATION [Complete <u>ONLY</u> if patient is <u>ALREADY</u> 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 ____/____/____ for the following diagnosis (ICD-9-CM diagnosis code specific to 4th or 5th digit or narrative): _____	
Prescriber's Signature _____ Date ____/____/____ <small>mm dd yyyy</small>	
Prescriber's Name [print] (last) _____ (first) _____ (mi) _____	
Address: _____	City: _____ State: _____ Zip: _____
Phone: _____	Fax: _____ NPI: _____
Goal at the completion of Invia® Wound Therapy: <input type="checkbox"/> Assist granulation tissue formation <input type="checkbox"/> Delayed primary closure (tertiary)	
PRODUCTS PROVIDED	
Upon establishment of medical necessity, Armscare will ship 15 wound dressing sets per month per wound. If you would like to make this a special request for other supplies, please check here _____ and an Armscare customer service representative will contact you regarding this.	
Requested delivery date: ____/____/____ [Please allow at least 24 hours following review of completed form.] <small>mm dd yyyy</small>	