

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: ____/____/____ <small>mm dd yyyy</small>		SS# _____ - _____ - _____	
1) Has the clinical care provider for this patient changed in the last 30 days? <input type="checkbox"/> No <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes ⇨ If Yes, Placement Date: ____/____/____ <small>mm dd yyyy</small>			
Placement measurements ⇨ Length: _____ cm Width: _____ cm Depth: _____ cm			
3) Was the patient admitted to a hospital or SNF within the last 30 days? <input type="checkbox"/> No <input type="checkbox"/> Yes			
If Yes, date admitted: ____/____/____ <small>mm dd yyyy</small>		Date discharged: ____/____/____ <small>mm dd yyyy</small>	
Name of facility: _____ Facility phone: _____			
Was the patient using the NPWT during this inpatient stay? <input type="checkbox"/> No <input type="checkbox"/> Yes			
4) Was NPWT suspended at any time during the last 30 days? <input type="checkbox"/> No <input type="checkbox"/> Yes			
If Yes, date suspended: ____/____/____ <small>mm dd yyyy</small>		Date restarted: ____/____/____ <small>mm dd yyyy</small>	
5) Is patient continuing treatment on NPWT? <input type="checkbox"/> No ⇨ Discharge Form <input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes ⇨ If Yes: <input type="checkbox"/> Mechanical <input type="checkbox"/> Chemical <input type="checkbox"/> Surgical			
If Surgical, date of debridement: ____/____/____ (Ensure measurements below are <u>after</u> most recent debridement.) <small>mm dd yyyy</small>			
2) Wound Location: _____ Measurement Date: ____/____/____ <small>mm dd yyyy</small>			
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 <input type="checkbox"/> beefy red <input type="checkbox"/> pale pink <input type="checkbox"/> gray		Wound margins <input type="checkbox"/> decreased <input type="checkbox"/> no change <input type="checkbox"/> increased	
Granulation tissue <input type="checkbox"/> increased <input type="checkbox"/> no change		Exudate amount <input type="checkbox"/> decreased <input type="checkbox"/> no change <input type="checkbox"/> increased	
Wound odor <input type="checkbox"/> decreased <input type="checkbox"/> no change <input type="checkbox"/> new		Exudate color <input type="checkbox"/> clear <input type="checkbox"/> pink <input type="checkbox"/> bloody	
		<input type="checkbox"/> 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? <input type="checkbox"/> No <input type="checkbox"/> Yes ⇨ If No, an Armscare customer service representative will contact you regarding this.			

_____ Licensed clinician's printed name, title	_____ Phone
_____ Signature	_____ Fax
_____ Date: mm / dd / yyyy	

For Armscare Use Only:	Information taken verbally by _____ from _____ <small>employee</small>
	_____ on _____ at _____ <small>(caregiver) Date: mm / dd / yyyy (time)</small>