Ri-Med
Patient Solutions
205-942-2650
Fax 205-942-5094

Physician's Prescription for Negative Pressure Wound Therapy (NPWT)

DO NOT USE THIS FORM WITH CHARITY PATIENTS

**** Must have all spaces completed and form signed by Physician****

Patient Name – Last:_____ **First:**_____ **D.O.B.**_____

Home Health Agency & Telephone Number: _____

_____

NPWT has been prescribed for the treatment or diagnosis of:_____

_____

_____

Set Pressure to:_____**mmHg - Continuous or Intermittent**

Monthly Supplies @ 10 Canisters 15 Dressing Kits - Circle Dressing Type: Foam White Foam Gauze

Order Date:_____ **ICD-10**_____

Wound Measurements:

Length - _____ **Width -** _____ **Depth -** _____

Length of Need: _____**Month(s)**

Physician Name:_____**NPI:**_____

Signature:_____**Date:**_____

Office Phone:_____ **Fax:**_____