



(Do Not Substitute)

Please fax this form to: 1-888-245-2295
Customer Service: 1-800-275-4524

V.A.C.® Ready Care Program Order? [] Yes [] No

1 Patient and insurance information (important: please submit demographic and/or insurance sheet)

Patient Full Name (print): _____ MI: _____ Patient DOB: ____/____/____ Gender: [] M [] F
(skip these questions if demographic/insurance sheet submitted) Patient Email: _____
Home Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____ Phone: _____
Emergency Contact (if available): _____ Phone: _____
Primary Insurance: _____ Policy#: _____ Secondary Insurance: _____ Policy#: _____

2 Prescriber information (complete in full or fax written prescription to include the following)

I prescribe V.A.C.® Therapy for the following wound type(s): [] Pressure Ulcer(s) [] Diabetic Ulcer(s) [] Venous Ulcer(s) [] Arterial Ulcer
[] Surgically Created [] Other: _____
I prescribe V.A.C.® Therapy for: [] 1 month [] 2 months [] 3 months [] 4 months [] Other (weeks): _____
and up to 15 V.A.C.® Therapy dressings per wound, per month, and up to 10 V.A.C.® Therapy canisters per month.
Provide narrative description specifying wound etiology and including anatomical location(s): _____
Therapy start date: ____/____/____ ICD-10 Code(s), if available: _____
Goal at the completion of V.A.C.® Therapy: [] Assist in granulation tissue formation [] Flap [] Graft [] Delayed primary closure (tertiary)
Prescriber Name (print): Last: _____ First: _____ MI: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Prescriber Phone: _____ Fax: _____ Email: _____ NPI: _____
[] Request an electronically signed prescription from prescriber (sent to email address listed above).

Prescriber only to sign and date. Original prescriber signature required. Stamps and photocopies strictly prohibited.

Prescriber Signature: _____ Signature Date: ____/____/____
By signing and dating, I attest that I am prescribing the V.A.C.® Negative Pressure Wound Therapy System (DO NOT SUBSTITUTE) as medically necessary, and all other applicable treatments have been tried or considered and ruled out. I have read and understand all safety information and other instructions for use included with the V.A.C.® Therapy product, as well as the V.A.C.® Therapy Clinical Guidelines. I also understand the V.A.C.® Therapy System contraindications.

3 Supplies for delivery (please check the V.A.C.® Dressing(s) requested)

V.A.C.® Peel and Place Dressing up to 7-day wear time [] Small [] Medium [] Large
Dermatac™ Drape with V.A.C.® Granufoam™ Dressing Kit [] Small [] Medium [] Large
V.A.C.® Granufoam™ Dressing [] Small [] Medium [] Large
V.A.C.® Simplace™ Dressing [] Small [] Medium
V.A.C.® Simplace™ Ex Dressing [] Small [] Medium
V.A.C.® Granufoam™ Bridge Dressing []
V.A.C.® Granufoam™ Bridge XG Dressing []
V.A.C.® Whitefoam™ Dressing Foam Only [] Small [] Large
V.A.C.® Whitefoam™ Dressing Kit [] Small [] Large
Other: _____ Qty: _____

4 Requestor and Post-Acute Clinical Provider information (please complete in full)

Delivery Need By Date: ____/____/____ Need By Time: _____ [] a.m. [] p.m.
Requestor Name and Title: _____ Requestor Phone: _____
Requestor Facility: _____
Address: _____ City: _____ State: _____ Zip: _____
Required: Email (for order status and follow up): _____
Delivery Location: [] Private Residence [] Facility/RM#: _____ [] Other: _____
Delivery Address: _____ City: _____ State: _____ Zip: _____
Location of V.A.C.® Therapy Use: [] Private Residence [] Wound Care Clinic [] SNF [] LTAC/Rehab [] Assisted Living
[] Other: _____
Post-Acute Clinical Provider (responsible for dressing changes): _____ Required: Phone: _____
Address: _____ City: _____ State: _____ Zip: _____
V.A.C.® Therapy: ActiV.A.C.™ Therapy System, Model Number 340000, or ActiV.A.C.™ Therapy System with iOn Progress™ Remote Therapy Monitoring, Model Number RTMGSM01/US

5a Clinical information by wound type

1. Was NPWT initiated in one of these in-patient facilities? Hospital LTAC SNF Date Initiated: ____/____/____
OR has the patient been on NPWT anytime during the last 60 days? Yes No Facility Name: _____
2. Is the patient's nutritional status compromised? Yes No Facility City/State: _____
If Yes, check the action taken: Protein supplements Enteral/NG feeding TPN Vitamin therapy Special diet
3. Indicate other therapies that have been previously tried and/or failed to maintain a moist wound environment:
 Saline Gauze Hydrogel Alginate Hydrocolloid Absorptive None Other: _____
4. If other therapies were considered and ruled out, what conditions prevented you from using other therapies prior to applying V.A.C.® Therapy?
 Presence of co-morbidities High risk of infections Need for accelerated granulation tissue Prior history of delayed wound healing
 Other (please describe): _____
5. Which of the following co-morbidities apply? Diabetes ESRD PVD PAD Immunocompromised Obesity Depression
 Smoking Para Quad WC Dependent Bedbound Not Applicable
6. If above diabetes box checked, is the patient on a comprehensive diabetic management program? Yes No Not Applicable
7. Is Osteomyelitis present in wound? Yes No If yes, please indicate the following:
 Antibiotic (list name): _____ IV Antibiotics (list name): _____ Hyperbaric Oxygen
Is the above treatment administered to the patient with the intention to completely resolve the underlying bone infection? Yes No
8. Please provide a short narrative of possible consequences if V.A.C.® Therapy is not used. (include/attach any clinical data such as H&P, OP report, and other medical documentation supporting treatments tried and describing factors impacting wound healing):

5b Patient's primary wound type (please select one)

- Pressure Ulcer** Stage III Stage IV
1. Is the patient being turned/positioned? Yes No
2. Has a group 2 or 3 surface been used for ulcer located on the posterior trunk or pelvis? Yes No
3. Are moisture and/or incontinence being managed? Yes No
4. Is pressure ulcer greater than 30 days? Yes No
- Diabetic Ulcer/Neuropathic Ulcer**
1. Has a reduction of pressure on the foot ulcer been accomplished with appropriate modalities? Yes No
- Venous Stasis Ulcer/Venous Insufficiency**
1. Are compression bandages and/or garments being consistently applied? Yes No
2. Is elevation/ambulation being encouraged? Yes No
- Arterial Ulcer/Arterial Insufficiency**
1. Is pressure over the wound being relieved? Yes No
- Surgical**
1. Was or will the wound be surgically created and not another wound type listed in section 5b? Yes No
2. Has the surgery taken place yet? Yes No
3. Date of surgical procedure involving wound: ____/____/____
4. Description of the surgical procedure pertaining to the wound: _____
- If Cancer Related Wound:** Include pathology report.
- Other Wound Type (describe):** _____
- Please complete if applicable:
Is wound a direct result of an accident? Yes No
If Yes, complete the following: Date of Accident: ____/____/____
Accident type: Auto Employment Trauma

5c Wound(s) description

- Wound #1 Type: _____ Age (months): _____
Wound Location: _____
- Is there eschar tissue present in the wound? Yes No
- Was debridement attempted in the last 10 days? Yes No
- If yes, debridement date: ____/____/____ Type: _____
- Are serial debridements required? Yes No
- Measurement Date:** ____/____/____
- Length:** _____ cm **Width:** _____ cm **Depth:** _____ cm
- Appearance of wound bed and color: _____
- Exudate (amount and color): _____
- Is the wound full thickness? Yes No
- Is muscle, tendon or bone exposed? Yes No
- Is there undermining? Yes No
- Location #1: _____ cm, from _____ to _____ o'clock
- Location #2: _____ cm, from _____ to _____ o'clock
- Is there tunneling/sinus? Yes No
- Location #1: _____ cm, at _____ o'clock
- Location #2: _____ cm, at _____ o'clock

- Wound #2 Type: _____ Age (months): _____
Wound Location: _____
- Is there eschar tissue present in the wound? Yes No
- Was debridement attempted in the last 10 days? Yes No
- If yes, debridement date: ____/____/____ Type: _____
- Are serial debridements required? Yes No
- Measurement Date:** ____/____/____
- Length:** _____ cm **Width:** _____ cm **Depth:** _____ cm
- Appearance of wound bed and color: _____
- Exudate (amount and color): _____
- Is the wound full thickness? Yes No
- Is muscle, tendon or bone exposed? Yes No
- Is there undermining? Yes No
- Location #1: _____ cm, from _____ to _____ o'clock
- Location #2: _____ cm, from _____ to _____ o'clock
- Is there tunneling/sinus? Yes No
- Location #1: _____ cm, at _____ o'clock
- Location #2: _____ cm, at _____ o'clock