

# Negative Pressure Wound Therapy Referral Form

Name:		Health Card #:		Version Code:	
Address:			Postal Code:		
Date of Birth:		Phone:			
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Non-binary <input type="checkbox"/> Unknown Pronouns:					
Diagnosis:				Diabetic: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Allergies: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Specify:			Latex Allergy: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
<b>WOUND TYPE</b>					
The following conditions can be considered for the application of NPWT. Please indicate reason for referral.					
Acute Wound	<input type="checkbox"/> Surgical (dehisced)	<input type="checkbox"/> Traumatic	<input type="checkbox"/> Abdominal	<input type="checkbox"/> Pilonidal cyst	<input type="checkbox"/> Partial thickness burn
Chronic Open Wound	<input type="checkbox"/> Diabetic ulcer (offloaded) <input type="checkbox"/> Venous leg ulcer <input type="checkbox"/> Stage 3 or 4 pressure injury (offloaded)				
Adjunct to Surgery	<input type="checkbox"/> Preparation of wound bed <input type="checkbox"/> Incisional support <input type="checkbox"/> Securing skin graft post-operatively				
Oncology Related	<input type="checkbox"/> Wound complicated by radiation <input type="checkbox"/> Support wound healing prior to start of chemotherapy				
<b>WOUND DESCRIPTION</b>					
Location:		Length:      cm x Width:      cm x Depth:      cm			
<input type="checkbox"/> Undermining    Details if applicable:		<input type="checkbox"/> Tunneling    Details if applicable:			
<b>Note: NPWT will continue to be assessed in the community, and settings may be reviewed based on exudate and patient tolerance. Continuation of NPWT is dependent on wound healing goals being met. Maximum treatment time for NPWT is 8 weeks.</b>					
<b>NPWT TREATMENT ORDERS</b>					
<input type="checkbox"/> <b>ActiVAC</b> (indicate pressure settings and dressing details below)  Pressure (mmHg): _____ <input type="checkbox"/> Continuous <b>OR</b> <input type="checkbox"/> Intermittent  Dressing (select one):  Granufoam Black: <input type="checkbox"/> Small (10cm x 7.5cm x 3.2cm) <input type="checkbox"/> Medium (18cm x 12.5cm x 3.2cm) <input type="checkbox"/> Large (26cm x 15cm x 3.2cm) <input type="checkbox"/> X-Large (60cm x 30cm x 3.2cm)  White Foam: <input type="checkbox"/> Small (10cm x 7.5cm x 1cm) <input type="checkbox"/> Large (10cm x 15cm x 1cm)			<input type="checkbox"/> <b>PICO</b> (single use, disposable) Pressure: <input type="checkbox"/> 80 mmHg (non-adjustable)  Dressing Size: <input type="checkbox"/> 10cm x 20cm <input type="checkbox"/> 10cm x 30cm <input type="checkbox"/> 15cm x 15cm  <input type="checkbox"/> <b>VIA</b> (single use, disposable) Pressure: <input type="checkbox"/> 75 mmHg <b>OR</b> <input type="checkbox"/> 125 mmHg  Dressing Size: <input type="checkbox"/> 14.5cm x17cm  <input type="checkbox"/> <b>SNAP</b> (single use, disposable) Pressure: <input type="checkbox"/> 125 mmHg (non-adjustable)  Dressing Size: <input type="checkbox"/> 10cm x 10cm <input type="checkbox"/> 15cm x 15cm		
<b>CONVENTIONAL DRESSING ORDERS</b>					

Patients will be started on conventional dressings until NPWT can be initiated. Conventional orders also required in the case of service interruption.

<b>Patient Name:</b>	<b>HCN:</b>
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**PRECAUTIONS AND CONTRAINDICATIONS**

The precautions and contraindications listed below have been reviewed, and it is determined that NPWT is appropriate to be used for patient  
 **YES**     **NO** (conventional dressings will be utilized until addressed)

<p>The following conditions are considered precautions in the use of NPWT:</p> <ul style="list-style-type: none"><li>• Immunodeficiency (e.g. Leukemia, HIV);</li><li>• Hematologic disorders;</li><li>• Systemic or local signs of infection;</li><li>• Uncontrolled diabetes;</li><li>• Systemic steroids;</li><li>• Receiving anticoagulant therapy;</li><li>• The location of the wound will interfere with the therapy;</li><li>• Nutritional impairment;</li><li>• History of non-compliance;</li><li>• Home environment not conducive to NPWT (i.e. cleanliness, animals etc.); or</li><li>• Patient unable to adhere to minimum of 22 hours of therapy/day.</li></ul>	<p>The following risk factors contraindicate the use of NPWT:</p> <ul style="list-style-type: none"><li>• Inadequate wound visualization;</li><li>• Untreated infection in the wound site;</li><li>• Fistulas to body cavities or organs;</li><li>• Presence of unbridged necrotic tissue with eschar;</li><li>• Untreated Osteomyelitis;</li><li>• Malignancy or cancer in the wound margins;</li><li>• Unresolved bleeding following debridement; or</li><li>• Exposed vasculature, nerves or organ</li></ul>
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**PRESCRIBER INFORMATION**

Name:	Phone:	Fax:	After Hours Number:
Signature:	CPSO/CNO#:	Date:	