

## Negative Pressure Wound Therapy (NPWT) Referral Form

| PATIENT INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                    |  |
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| Name:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                            | Health Card No and Version Code:                                                                                                                                                                                                                                                                                                                                                                                   |  |
| Address:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                            | Postal Code:                                                                                                                                                                                                                                                                                                                                                                                                       |  |
| Date of Birth (dd-mmm-yyyy):                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                            | 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                                                                                                                                                                                                                                                                                                           |  |
| WOUND TYPE                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                    |  |
| The following conditions can be considered for the application of NPWT. Please indicate reason for referral.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                    |  |
| Acute Wound                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <input type="checkbox"/> Surgical (dehiscid) <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 post-operatively <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                                                                      |                                                                                                                                                                                                                                                                                                                                                                                                                    |  |
| WOUND DESCRIPTION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                    |  |
| 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>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                    |  |
| NPWT TREATMENT ORDERS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                                                                                                                                    |  |
| <input type="checkbox"/> <b>ActiVAC</b> (indicate pressure settings and dressing details below)<br><br>Pressure (mmHg): <input type="checkbox"/> Continuous <b>OR</b> <input type="checkbox"/> Intermittent<br><br>Dressing ( <i>select all that apply</i> )<br><br><div style="display: flex; justify-content: space-between;"> <div> <b>Granufoam Black:</b><br/> <input type="checkbox"/> Small (10 cm x 7.5 cm x 3.2 cm)<br/> <input type="checkbox"/> Medium (18 cm x 12.5 cm x 3.2 cm)<br/> <input type="checkbox"/> Large (26 cm x 15 cm x 3.2 cm)<br/> <input type="checkbox"/> X-Large (60 cm x 30 cm x 3.2 cm) </div> <div> <b>Granufoam Silver:</b><br/> <input type="checkbox"/> Small (10 cm x 7.5 cm x 3.2 cm)<br/> <input type="checkbox"/> Medium (18 cm x 12.5 cm x 3.2 cm)<br/> <input type="checkbox"/> Large (26 cm x 15 cm x 3.2 cm) </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div> <b>White Foam:</b><br/> <input type="checkbox"/> Small (10 cm x 7.5 cm x 1 cm)<br/> <input type="checkbox"/> Large (10 cm x 15 cm x 1 cm) </div> <div> <b>Simplace Ex:</b><br/> <input type="checkbox"/> Small (7.7 cm x 11.2 cm x 1.75 cm)<br/> <input type="checkbox"/> Medium (14.7 cm x 17.4 cm x 1.75 cm) </div> </div> <b>Peel and Place:</b><br>* Peel and Place cannot be used with tunneling or undermining > 2cm<br><input type="checkbox"/> Small (wound size less than 6.1 x 8.6 cm, MAX 2 cm deep)<br><input type="checkbox"/> Medium (wound size less than 11.1 x 16.6 cm, MAX 4 cm deep)<br><input type="checkbox"/> Large (wound size less than 13.6 x 24.2 cm, MAX 6 cm deep) |                                                                                                                                                                                                            | <input type="checkbox"/> <b>PICO</b> (single use, disposable)<br><br>Pressure: <input type="checkbox"/> 80 mmHg (non-adjustable)<br><br>Dressing Size:<br><input type="checkbox"/> 10 cm x 20 cm<br><input type="checkbox"/> 10 cm x 30 cm<br><input type="checkbox"/> 15 cm x 15 cm<br><input type="checkbox"/> 15 cm x 20 cm<br><input type="checkbox"/> 15 cm x 30 cm<br><input type="checkbox"/> 20 cm x 20 cm |  |
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| <b>Patient Name:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | <b>HCN:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |
| <b>CONVENTIONAL DRESSING ORDERS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <p>Patients will be started on conventional dressings until NPWT can be initiated. Conventional orders also required in the case of service interruption.</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>PRECAUTIONS AND CONTRAINDICATIONS</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <p>The precautions and contraindications listed below have been reviewed, and its determined that NPWT is appropriate to be used for patient</p> <p><input type="checkbox"/> <b>Yes</b>   <input type="checkbox"/> <b>No</b> (conventional dressings will be utilized until addressed)</p>                                                                                                                                                                                                                                                                                                                                                                           |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <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 undebrided 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> |
| <b>PRESCRIBER INFORMATION</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
| <b>Name:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | <b>Phone:</b> <b>Fax:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |
| <b>Signature:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>After Hours Number:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
| <b>CPSO/CNO#:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | <b>Date:</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |