LIBERTY MEDICAL SPECIALTIES

STANDARD WRITTEN ORDER / CMN
Negative Pressure Wound Therapy
612-10 Jefferson Street, Whiteville, NC 28472
1-800-297-7567 (Phone) · 1-910-719-9025 (Fax)

*** Date of Order** _____

*** Patient Name** _____ DOB _____

Primary Diagnosis _____

EQUIPMENT AND SUPPLIES

☐ E2402 – Negative Pressure Wound Therapy Pump

☐ A7000 – Disposable Canister for Pump 10/M

☐ A6550 – Negative Pressure Wound Therapy Dressing Set 15/M

I prescribe NPWT pump and supplies for _____ months*.

Change dressing (how often) _____ setting to be placed at _____ MMMHG.

☐ Foam ☐ Gauze.

☐ Patient to apply wet to dry normal saline dressing if equipment failure occurs.

*** Print Name or NPI** _____

*** Physician/Treating Practitioner Signature** _____

By my signature, I attest that I am prescribing NPWT as medically necessary and all other applicable treatments have been tried or considered and ruled out. I have read and understood all safety information and other instructions for NPWT as well as NPWT clinical guidelines.

*** Medicare Required Fields**