Ontario Health atHome

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# Negative Pressure Wound Therapy (NPWT) Referral Form

| PATIENT INFORMATION | |
|---|---|
| Name: | Health Card No and Version Code: |
| Address: | Postal Code: |
| Date of Birth (dd-mmm-yyyy): | Phone: |
| Gender: ☐ Male ☐ Female ☐ Non-binary ☐ Unknown | Pronouns: |
| Diagnosis: | Diabetic: ☐ Yes ☐ No |
| Allergies: ☐ Yes ☐ No ☐ Unknown Specify: | Latex Allergy: ☐ Yes ☐ No ☐ Unknown |

| WOUND TYPE | |
|---|---|
| The following conditions can be considered for the application of NPWT. Please indicate reason for referral. | |
| Acute Wound | ☐ Surgical (dehisced) ☐ Traumatic ☐ Abdominal ☐ Pilonidal cyst ☐ Partial thickness burn |
| Chronic Open Wound | ☐ Diabetic ulcer (offloaded) ☐ Venous leg ulcer ☐ Stage 3 or 4 pressure injury (offloaded) |
| Adjunct to Surgery | ☐ Preparation of wound bed post-operatively ☐ Incisional support ☐ Securing skin graft post-operatively |
| Oncology Related | ☐ Wound complicated by radiation ☐ Support wound healing prior to start of chemotherapy |

| WOUND DESCRIPTION | |
|---|---|
| Location: | Length: cm x Width: cm x Depth: cm |
| ☐ Undermining Details if applicable: | ☐ Tunneling Details if applicable: |

**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.**

## NPWT TREATMENT ORDERS

☐ **ActiVAC** (indicate pressure settings and dressing details below)

Pressure (mmHg): ☐ Continuous **OR** ☐ Intermittent

Dressing *(select all that apply)*

*Granufoam Black*:
- ☐ Small (10 cm x 7.5 cm x 3.2 cm)
- ☐ Medium (18 cm x 12.5 cm x 3.2 cm)
- ☐ Large (26 cm x 15 cm x 3.2 cm)
- ☐ X-Large (60 cm x 30 cm x 3.2 cm)

*Granufoam Silver:*
- ☐ Small (10 cm x 7.5 cm x 3.2 cm)
- ☐ Medium (18 cm x 12.5 cm x 3.2 cm)
- ☐ Large (26 cm x 15 cm x 3.2 cm)

*White Foam*:
- ☐ Small (10 cm x 7.5 cm x 1 cm)
- ☐ Large (10 cm x 15 cm x 1 cm)

*Simplace Ex*:
- ☐ Small (7.7 cm x 11.2 cm x 1.75 cm)
- ☐ Medium (14.7 cm x 17.4 cm x 1.75 cm)

*Peel and Place*:
* Peel and Place cannot be used with tunneling or undermining > 2cm
- ☐ Small (wound size less than 6.1 x 8.6 cm, MAX 2 cm deep)
- ☐ Medium (wound size less than 11.1 x 16.6 cm, MAX 4 cm deep)
- ☐ Large (wound size less than 13.6 x 24.2 cm, MAX 6 cm deep)

☐ **PICO** (single use, disposable)

Pressure: ☐ 80 mmHg (non-adjustable)

Dressing Size:
- ☐ 10 cm x 20 cm
- ☐ 10 cm x 30 cm
- ☐ 15 cm x 15 cm
- ☐ 15 cm x 20 cm
- ☐ 15 cm x 30 cm
- ☐ 20 cm x 20 cm

☐ **SNAP** (single use, disposable)

Pressure: ☐ 125 mmHg (non-adjustable)

Dressing Size:

☐ 10 cm x 10 cm ☐ 15 cm x 15 cm

SNAP Therapy Strap Size:

☐ Small ☐ Medium ☐ Large

| **Patient Name:** | **HCN:** |
|---|---|

## CONVENTIONAL DRESSING ORDERS

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

## PRECAUTIONS AND CONTRAINDICATIONS

The precautions and contraindications listed below have been reviewed, and its determined that NPWT is appropriate to be used for patient

☐ **Yes** ☐ **No** (conventional dressings will be utilized until addressed)

The following conditions are considered precautions in the use of NPWT:

- Immunodeficiency (e.g. Leukemia, HIV);
- Hematologic disorders;
- Systemic or local signs of infection;
- Uncontrolled diabetes;
- Systemic steroids;
- Receiving anticoagulant therapy;
- The location of the wound will interfere with the therapy;
- Nutritional impairment;
- History of non-compliance;
- Home environment not conducive to NPWT (i.e. cleanliness, animals, etc.); or
- Patient unable to adhere to minimum of 22 hours of therapy/day.

The following risk factors contraindicate the use of NPWT;

- Inadequate wound visualization;
- Untreated infection in the wound site;
- Fistulas to body cavities or organs;
- Presence of undebrided necrotic tissue with eschar;
- Untreated Osteomyelitis;
- Malignancy or cancer in the wound margins;
- Unresolved bleeding following debridement; or
- Exposed vasculature, nerves or organ

## PRESCRIBER INFORMATION

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