NATROX® OXYGEN WOUND THERAPY
Rx AND PATIENT INFORMATION FORM

Patient Name:		**DOB: (MM/DD/YYYY)**	**Age:**
Address:	**City:**	**State:**	**Zip:**
Insurance Co.:	**ID #:**		
Home Phone:	**Mobile Phone:**		**Gender:**
Patients Medicaid ID #:	**ICD-10 Code(s):**		
I prescribe NATROX® Oxygen Wound Therapy. Through a combination of an (OG) Oxygen Generator a wound monitoring system and (ODS) Oxygen Delivery System's; this therapy is prescribed to provide full closure to patients suffering from difficult-to-heal wounds. **Anticipated Start Date:**			

Physician's Signature: _____ Date: _____

By my signature I am prescribing Continuous Diffusion of Oxygen (CDO) Therapy as medically necessary. Original signature required.

PRESCRIBING PHYSICIAN'S INFORMATION:

Physician's Name:	**Professional License #:**	**NPI:**
Medical License #:	**Phone #:**	**Fax #:**
Street Address:	**City, State:**	**Zip Code:**

INSURANCE INFORMATION:

NOTE: Please include a copy of patient's demographic and insurance information, including Medicaid MCO Card(s) referenced below.

Primary Insurance:			**Primary Insured's Name:**			**DOB: (MM/DD/YYYY)**	
Patients Relationship to Insured: **(Please check below)**						**Age:**	**Gender:**
	Self		**Spouse**		**Child**		**Other:** _____
Primary Insurance Phone #:			**Policy #:**			**Group #:**	
Secondary Insurance:			**Policy #:**			**Group #:**	
Auto Insurance/Workers Comp. Info:			**Phone #:**			**Employer Name:**	

NATROX® OXYGEN WOUND THERAPY CLINICAL INFORMATION FORM

Patient Name:		DOB: (MM/DD/YYYY)	Gender:
Address:	**City:**	**State:**	**Zip Code:**
Insurance Co.:	**ID #:**		
Home Phone:	**Mobile Phone:**		

Wound Type:	ICD-10 Dx Code(s):		Wound Age: _____months
Serial Debridement: Y / N	**Last Debridement Date:**	**Debridement Type:**	**Tunneling: Y / N**

Wound Measurements:

	Measurement Date:	Length (cm):	Width (cm):	Depth (cm):	Measurement Date:	Length (cm):	Width (cm):	Depth (cm):
1								
2								

Wound Type/Indications (check appropriate):

	Amputation-Diabetic		Dehisced
	Amputation-Traumatic		Diabetic Ulceration
	Arterial Ulceration		Neuropathic Ulceration
	Venous Ulceration		Surgical Wound (Non-Dehisced)
	Burn		Other:

Current/Prior Treatments:

	Silvadene		Wet to Dry Dressing		Debridement
	Compression		Antibiotics		Santyl/Collagenase
	Unna Boot		Off Loading		Other:

Therapies previously utilized to maintain a moist wound environment:

- **Saline/Gauze**
- **Other:** _____

Venous Insufficiency Ulceration:

Compression bandages and or garments have been consistently applied? Y / N
Leg elevation and ambulation have been encouraged? Y / N

Neuropathic/Diabetic Ulcer:

Is foot pressure being reduced? Y / N
Is patient on diabetic management program? Y / N

Pressure Ulcer:

Is patient being appropriately turned and positioned? Y / N

Medical Notes Attached: Y / N

Goal of CDO Therapy is to assist in granulation tissue formation and closure/complete healing of the wound(s).

Physician's Signature: _____ Date: _____

NATROX® OXYGEN WOUND THERAPY LETTER OF MEDICAL NECESSITY

Patient Name:	DOB: (MM/DD/YYYY)	Gender:

Address:	City:	State:	Zip Code:

Insurance Co.:	ID #:
Home Phone:	Mobile Phone:

Wound #1 Location:	Wound #1 Type:	ICD-10 Code(s):
Wound #2 Location:	Wound #2 Type:	ICD-10 Code(s):

Medical Necessity for Patient:

_____

_____

_____

_____

_____

Clinical Risks Without Use of NATROX® OXYGEN WOUND THERAPY:

_____

_____

_____

_____

_____

_____

Continuation of Therapy Date: _____

Rx Weeks: _____

Rx Quantity: _____ **(16 units = 4 weeks/wound)**

Physician's
Signature _____ Date _____

NATROX OXYGEN WOUND THERAPY
Wound Report

Patient Information:

Patient Name: _____Phone Number: _____
Current Week: _____ Date: _____

Is patient currently receiving **NATROX OXYGEN WOUND THERAPY?**___YES ___NO
Has the patient been an inpatient at any medical facility in the past 30 days? ___YES ___NO
If YES please provide all required Medicaid/Medicare Documentation:
_____
_____
Date of patients last debridement: _____ Type: _____
Is the patient's wound infected? ___YES ___NO
Has patient been treated for any infection in the past 30 days? ___YES ___NO
If YES, please list type and treatment: _____
Is patient Compliant? ___YES ___NO
Treatment schedule for patient for past 30 days: _____
For any reason has there been an interruption in **NATROX OXYGEN WOUND THERAPY?** ___YES ___NO
If YES, please explain: _____
Have there been any clinical changes in the past 30 days (infection, medications, smoking, nutrition, that would prevent wound(s) from healing? ___YES ___NO
If YES, please explain:_____
Does patient have any contraindications to **NATROX OXYGEN WOUND THERAPY?**___YES ___NO
If YES, please explain: _____
Patient Risk Factors: _____

NUMBER	**WOUND #1**	**WOUND #2**
LOCATION		
MEASUREMENTS	L_____ W_____D_____	L_____ W_____ D_____
COLOR	_____RED_____YELLOW_____BLACK	_____RED_____YELLOW_____BLACK
TISSUE GRANULATION	_____BRIGHT RED _____PINK _____NONE	_____BRIGHT RED _____PINK _____NONE
ODOR	_____YES _____NO	_____YES _____NO
DRAINAGE	_____NONE _____SCANT _____MODERATE _____HEAVY	_____NONE _____SCANT _____MODERATE _____HEAVY
EXUDATE	_____NONE _____SCANT _____MODERATE _____HEAVY	_____NONE _____SCANT _____MODERATE _____HEAVY
SLOUGH	_____NONE _____SCANT _____MODERATE _____HEAVY	_____NONE _____SCANT _____MODERATE _____HEAVY
NECROTIC	_____NONE _____SCANT _____MODERATE _____HEAVY	_____NONE _____SCANT _____MODERATE _____HEAVY
TUNNELING	_____YES _____NO	_____YES _____NO
UNDERMINING	_____YES _____NO	_____YES _____NO
EXPOSED BONE	_____YES _____NO	_____YES _____NO
EXPOSED TENDON	_____YES _____NO	_____YES _____NO
EPITHELIZATION	_____YES _____NO	_____YES _____NO
REDUCED EDEMA	_____YES _____NO	_____YES _____NO
INFECTION	_____YES _____NO	_____YES _____NO
PHOTO TAKEN	_____YES _____NO	_____YES _____NO

Notes:_____
_____

Prescribers Signature: _____ Date: _____