Wound Vac Order Form

Patient Name: _____ Room#: _____

Ordering Physician: _____ Date: _____

Diagnosis: _____

Ordering process to follow: (check box when completed)

- ☐ Notify Charge Nurse of order
- ☐ Anticipated length of use _____ days _____ weeks
- ☐ Hospital Unit ☐ Home Unit
- ☐ Wound size/measurements:

  length_____cm width _____cm depth _____cm
- ☐ Select wound vac size (per PT or nursing assessment):

  ☐ small ☐ large wound vac
- ☐ Select foam type: ☐ gray/silver ☐ black ☐ white
- ☐ Additional supplies needed (per PT recommendation) _____

_____

_____

- ☐ Faxed to Purchasing (fax # 676-3777)
- ☐ Phone call placed to purchasing to confirm order received @ Ext. 370
- ☐ Faxed to Physical Therapy if Home Unit needed (fax # 676-0414)

Wound Vac arrived to floor on _____ (date)

Wound Vac applied by _____ (department/staff)

➢ **When use of wound vac is discontinued, please clean and return to Purchasing.**

Signatures/Initials

_____ Signature/Date/Time

_____ Signature/Date/Time

Patient Sticker