V.A.C. Therapy Funding Application Form

AHSA FUND MEMBERS

Use this form when V.A.C. Therapy is required without a hospital admission or where therapy has been commenced while patient is an admitted "in hospital" patient.

Note:

For funding to be considered outside of the hospital, VAC therapy must have commenced while the patient is in the hospital and it must be demonstrated that the wound has improved during this time.

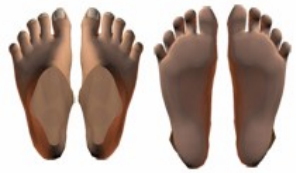
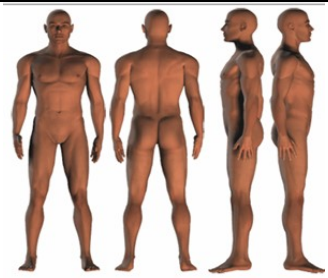
Member and Treating Doctor details:			
Member Name:	Member address:		
Health Fund: Membership number:	Contact number:	Date of Birth:	Gender:
Treating Doctor:	Phone: Fax	Date of Application:	
Care Provider:	Phone: Fax:	Commencement of Care (date):	
Do you expect that this patient could be successfully treated with V.A.C. therapy in the community?		**Yes / No**	
If approval is not given for funding of V.A.C therapy (in the home) is the patient likely to be admitted to hospital?		**Yes / No**	
If yes, to the above question, what is the likely duration of Hospitalisation?			
Do you agree to provide feedback on the wound status as required at intervals nominated by the health fund?		**Yes / No**	

Factors impairing the patient's capacity to heal: (please tick)			
Advancing age and general immobility		Excess local mobility	
Obesity		Smoking	
Diabetes		Malnutrition	

Inadequate blood supply (PVD)		Poor venous drainage	
Increased skin tension		Wound dehiscence	
Infection		Anaemia/ haematological disease	
Malignancy		Chemotherapy / radiotherapy	
Immunosuppressed		Osteomyelitis	
Other: (describe)			

Therapy Goal (endpoint):	**Please select:**	**Expected time frame (weeks)**
Surgical wound closure (post V.A.C. therapy)		
Wound closure / full epithelialisation		
Prepare wound bed for skin graft		
Application of skin graft		
Resolution of infection		
Palliative		
Exudate management		

Treatment Details:	
Frequency of review by doctor:	
Anticipated frequency of change of dressings:	
Anticipated number of visits per week by care giver (nurse)	

Wound Details:		
Wound type: (Select)	Wound location: (Please cross area)	
Trauma/acute Sub acute / dehiscence Chronic – venous ulcer Chronic – PU Chronic – diabetic ulcer		
Duration of wound:	Current status of wound: Further debridement required:	**Clean / Infected** **Yes / No**
Has the VAC therapy commenced (while the patient is "in hospital") (prior to HITH or substitute care)		

When did the VAC therapy commence?	
Has the wound shown improvement since commencement of VAC therapy? Please provide details?	
Previous treatment: (e.g. debridement + date)	
Response to previous treatment : (describe)	
Current treatment:	

Wound Size:							
Length	mm	Width	mm	Depth	mm		
Surface Area	cm^2	Volume	cm^3	Image taken	Yes /No		

Wound Description: (please tick)								
Wound Appearance:	Sloughy		Infected		Necrotic		Granulation present	
Wound Bed color:	Red		Yellow / sloughy		Black / Eschar			
Wound Edge:	Viable		Rolled		Fibrotic		Closed	
Presence of:	Undermining		Tunneling					
Peri wound appearance:	Intact		Macerated		Denuded		Reddened	

Patient compliance and suitability:	
Is patient or carer able to carry device, change canister and recharge battery?	Yes / No
Will the patient be able to troubleshoot as necessary?	Yes / No

Does the patient have the capacity to continue therapy unsupervised?	Yes / No
Has the patient demonstrated past willingness to participate in their care?	Yes / No
Does the actual care provider (nursing service) provide 24 hour support?	Yes / No

Signature of treating doctor:		Date:
For Fund Use Only		
Approval for V.A.C. therapy		Yes / No
Review Period: e.g. fortnightly, 3 weekly	Frequency: Commencement date	
Treating Physician notified of Decision and details: Date:		Yes / No
Name and signature of Health Fund Assessor:		Date: