

Topical Wound Oxygen (TWO₂) Therapy Form

Name of Person Completing Form _____ Phone _____ Date _____
 Patient Name _____ Social Security # _____ Birthdate _____
 Address _____ City _____ State _____ Zip _____
 Male Female Phone# _____ Family Contact _____ Phone _____
 Organization providing clinical care _____ Phone _____
 Medicare Medicaid Private Insurance HIC/ID# _____ Group # _____
 Secondary Insurance Provider _____ Group # _____

Patient and Wound Information

- 1 Did patient have Topical Wound Oxygen (TWO₂) in a hospital? Yes No If yes, what hospital? _____
- 2 What dressing applications have been used to maintain a moist wound environment?
 Absorbative Alginate Hydrogel Hydrocolloid Saline Soaked Gauze Other
- 3 Debridement of necrotic tissue? Yes No N/A
- 4 Does patient have compromised nutritional status? Yes No If yes, please choose all that apply:
 Enteral/NG Feeding Protein Supplements Special Diet TPN Vitamin Therapy Other _____
- 5 Was patient on TWO₂ in the last 2 months? Yes No If yes, where? _____

Wound Type Information

- Pressure Ulcer** Stage III Stage IV
 Patient been appropriately turned and positioned? Yes No N/A
 Patient has used a Group 2 or 3 support surface for ulcers on the posterior trunk or pelvis? Yes No N/A
 Moisture and incontinence being managed? Yes No N/A
- Neuropathic/Diabetic Ulcer**
 Patient is on a diabetic management program? Yes No N/A
 Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities? Yes No N/A
- Venous insufficiency Ulcer**
 Compression bandages and or garments have been consistently applied? Yes No
 Leg elevation and ambulation have been encouraged? Yes No

Wound Measurement Information *(Must be completed by licenced medical professional)*

Wound# _____ Type: _____ Wound Age _____ Location _____ Measurement Date _____ Length _____ Width _____ Depth _____ Exudate _____ ml/day <i>Measure wound at deepest depth</i> Tunneling? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, (length) _____ cm and (position) _____ o'clock	Wound# _____ Type: _____ Wound Age _____ Location _____ Measurement Date _____ Length _____ Width _____ Depth _____ Exudate _____ ml/day <i>Measure wound at deepest depth</i> Tunneling? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, (length) _____ cm and (position) _____ o'clock
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Prescription

- I prescribe TWO₂ therapy system to be applied for 90 minutes, 5 days per week for _____ days on the above named patient.

Date _____

DX: _____

Clinician Name (print) _____

Signature _____

Contraindications for TWO₂ are presence of necrotic tissue with eschar, untreated osteomyelitis within the vicinity of the wound, cancer present in the wound, presence of a fistula to an organ or body cavity within the vicinity of the wound, and/or exposed vessel or organ.

**Please complete and fax this form to AOTI, 1-760-863-3063 or mail it to
 2131 Palomar Airport Rd. Suite 350, Carlsbad, CA 92011. For more information visit www.aotinc.net**