



Please fax this form to KCI at

1-888-245-2295

V.A.C.® Therapy System Monthly Wound Progress Form†



Patient Name (Last): Doe (First): John (MI): L DOB: 3/10/1946
KCI Order #: XXXXXXXX Acct #: XXXXXXXX

1 Patient History

- 1. Is patient currently using the V.A.C.® Therapy System? [X] Yes [] No
2. Has the patient been admitted (Acute, SNF, LTAC) within the last 30 days? [] Yes [X] No
Admission date: ___/___/___ Discharge date: ___/___/___
Name of facility: _____
Facility phone: _____
Was the patient using the V.A.C.® Therapy System during this inpatient stay? [] Yes [X] No
3. Was V.A.C.® Therapy suspended at any time during the last 30 days? [X] Yes [] No
Date suspended: 08/14/08 Date resumed: 08/20/08
(If resumed, please enter resumption measurements in section 4.)
4. Has the patient been treated for wound infection in the last 30 days? [X] Yes [] No
Type of infection: [X] Staph [] MRSA [] Other: _____
Treatment: [] Debridement [X] Antibiotics [] Other: _____
5. Has the wound been debrided in the last 30 days? [X] Yes [] No
Post Debridement Measurements: L: 15 cm W: 2 cm D: 1 cm
Date of debridement: 08/01/08
Type of debridement: [X] Surgical/Sharp [] Enzymatic [] Chemical [] Mechanical [] Other: _____
6. Has there been any change in the patient's medical condition that would affect wound healing in the last 30 days (e.g., co-morbidities, medications, nutritional status, etc.)? [X] Yes [] No
If yes, please explain: infection

2 Clinician Information

Clinician's Printed Name: Jane Doe
Title: Wound Care Nurse
Employer: KCI Wound Care Center
Phone: 210-406-600 Fax: 210-555-2222

Clinician's Signature _____ Date: ___/___/___

Name and title of person completing form (if different): _____ Date: ___/___/___

3 Wound Characteristics

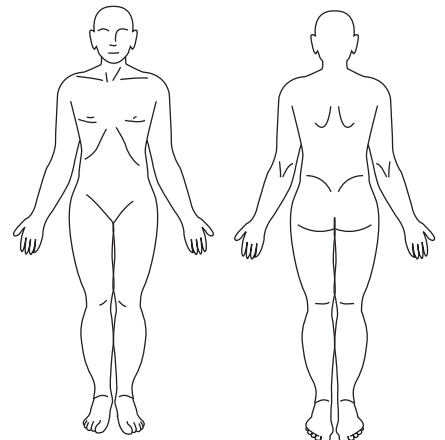
Exudate: [] Minimal [X] Moderate [] Heavy
Appearance of Exudate: [X] Serous [] Serosanguinous [] Purulent* [] Bloody*
Appearance of Wound Bed: [X] Beefy Red [] Red [] Pink [] White* [] Yellow*
Adverse Odor*, if any: (describe) _____

*Describe any treatment administered for noted characteristics: _____

4 Wound Measurements

Measurements: If wound depth varies, document the greatest depth
Number of wounds being treated? 1
If more than two wounds treated, use additional forms.
Wound #: 1 Location: abdomen
Measurement Date: 08 / 02 / 08
L: 14 cm W: 0.8 cm D: 1 cm
Sinus/Tunnel#1: _____ cm @ _____ o'clock.
Sinus/Tunnel#2: _____ cm @ _____ o'clock.
Undermining: _____ cm @ ___ to ___ o'clock.
Wound #: _____ Location: _____
Measurement Date: ___ / ___ / ___
L: _____ cm W: _____ cm D: _____ cm
Sinus/Tunnel#1: _____ cm @ _____ o'clock.
Sinus/Tunnel#2: _____ cm @ _____ o'clock.
Undermining: _____ cm @ ___ to ___ o'clock.

Please mark wound location on diagram:



†If V.A.C.® Therapy has been discontinued, please fill out a V.A.C.® Therapy System Discharge Form.