



Please fax this form to KCI at

1-888-245-2295

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



Patient Name (Last): _____ (First): _____ (MI): _____ DOB: _____

KCI Order #: _____ Acct #: _____

1 Patient History

- 1. Is patient currently using the V.A.C.® Therapy System?
2. Has the patient been admitted (Acute, SNF, LTAC) within the last 30 days?
3. Was V.A.C.® Therapy suspended at any time during the last 30 days?
4. Has the patient been treated for wound infection in the last 30 days?
5. Has the wound been debrided in the last 30 days?
6. Has there been any change in the patient's medical condition that would affect wound healing in the last 30 days?

2 Clinician Information

Clinician's Printed Name: _____
Title: _____
Employer: _____
Phone: _____ Fax: _____
Clinician's Signature _____ Date: ____/____/____
Name and title of person completing form (if different): _____ Date: ____/____/____

3 Wound Characteristics

- Exudate: Minimal Moderate Heavy
Appearance of Exudate: Serous Serosanguinous Purulent* Bloody*
Appearance of Wound Bed: 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?
Wound #: Location:
Measurement Date: L: W: D: Sinus/Tunnel#1: @ o'clock. Sinus/Tunnel#2: @ o'clock. Undermining: @ to o'clock.

Please mark wound location on diagram:

