



Please fax this form to KCI at

1-888-245-2295

# V.A.C.® Therapy System Discharge Form



Patient Name (Last): \_\_\_\_\_ (First): \_\_\_\_\_ (MI): \_\_\_\_\_ DOB: \_\_\_\_\_

KCI Order #: \_\_\_\_\_ Acct #: \_\_\_\_\_

## 1 Prescriber's Goal for Therapy

Was the prescriber's goal for therapy, \_\_\_\_\_, met?  Yes  No

## 2 Final Patient Assessment (indicate why V.A.C.® Therapy has been discontinued)

*(If more than two wounds treated, use additional forms)*

Please mark wound location on diagram:

Number of wounds being treated? \_\_\_\_\_

Wound #1

Wound location: \_\_\_\_\_ Date V.A.C.® Therapy discontinued: \_\_\_\_/\_\_\_\_/\_\_\_\_

Wound Status:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Adequate granulation    | <input type="checkbox"/> Patient in Nursing Home  | <input type="checkbox"/> Wound healed         |
| <input type="checkbox"/> Delayed primary closure | <input type="checkbox"/> Patient in Hospital/LTAC | <input type="checkbox"/> Wound sutured closed |
| <input type="checkbox"/> Non-compliant           | <input type="checkbox"/> Patient expired          | <input type="checkbox"/> Wound unresponsive   |
| <input type="checkbox"/> Pain                    | <input type="checkbox"/> Wound flapped            |   |
| <input type="checkbox"/> Patient in SNF          | <input type="checkbox"/> Wound grafted            |   |

Final dimensions (if not completely closed): L: \_\_\_\_cm W: \_\_\_\_cm D: \_\_\_\_cm Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

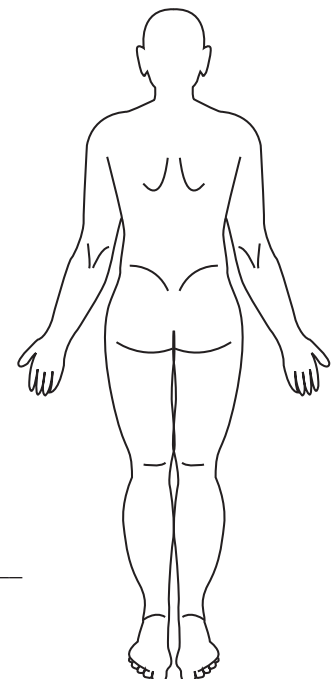
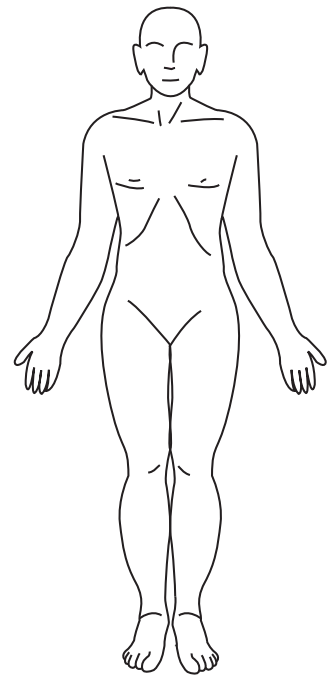
Wound #2

Wound location: \_\_\_\_\_ Date V.A.C.® Therapy discontinued: \_\_\_\_/\_\_\_\_/\_\_\_\_

Wound Status:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Adequate granulation    | <input type="checkbox"/> Patient in Nursing Home  | <input type="checkbox"/> Wound healed         |
| <input type="checkbox"/> Delayed primary closure | <input type="checkbox"/> Patient in Hospital/LTAC | <input type="checkbox"/> Wound sutured closed |
| <input type="checkbox"/> Non-compliant           | <input type="checkbox"/> Patient expired          | <input type="checkbox"/> Wound unresponsive   |
| <input type="checkbox"/> Pain                    | <input type="checkbox"/> Wound flapped            |   |
| <input type="checkbox"/> Patient in SNF          | <input type="checkbox"/> Wound grafted            |   |

Final dimensions (if not completely closed): L: \_\_\_\_cm W: \_\_\_\_cm D: \_\_\_\_cm Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



## 3 Signature

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

Employer: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

KCI Representative Name (if completed by KCI): \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_