



Please fax this form to KCI at

1-888-245-2295

V.A.C.® Therapy System Discharge Form



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

1 Prescriber's Goal for Therapy

Was the prescriber's goal for therapy, **promote granulation formation**, 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)

Number of wounds being treated? **1**

Wound #1

Wound location: **abdomen** Date V.A.C.® Therapy discontinued: **08 / 27 / 08**

Wound Status:

- Adequate granulation
- Delayed primary closure
- Non-compliant
- Pain
- Patient in SNF
- Patient in Nursing Home
- Patient in Hospital/LTAC
- Patient expired
- Wound flapped
- Wound grafted
- Wound healed
- Wound sutured closed
- Wound unresponsive

Final dimensions (if not completely closed): L: **13** cm W: **0.3** cm D: **0.3** cm Date: **08/27 / 08**

Wound #2

Wound location: _____ Date V.A.C.® Therapy discontinued: ____/____/____

Wound Status:

- Adequate granulation
- Delayed primary closure
- Non-compliant
- Pain
- Patient in SNF
- Patient in Nursing Home
- Patient in Hospital/LTAC
- Patient expired
- Wound flapped
- Wound grafted
- Wound healed
- Wound sutured closed
- Wound unresponsive

Final dimensions (if not completely closed): L: ____ cm W: ____ cm D: ____ cm Date: ____/____/____

3 Signature

Printed Name: **Jane Doe**

Title: **Wound Care Nurse**

Employer: **KCI Wound Care Center**

Phone: **210-406-6000** Fax: **210-555-1111**

KCI Representative Name (if completed by KCI): _____ Date: ____/____/____

Please mark wound location on diagram:

