Air Fluidized (AFT) – Fax Cover Sheet

RiMed Office Address

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Please fax this cover sheet with:

1. **Face Sheet**
2. **As much wound documentation as you can send 😊**
3. **AFT Physician Order Form (We will help populate this form)**

*POINT OF CONTACT (Nurse/Case Manager/Doc)

- Name:
- Contact Number:

Additional Notes We May Need to Know:

Date: / /

Physician Order Form for Air Fluidized Therapy Bed (E0194)

Patient Name: ______________________________________ **DOB:** ___________________ **LON:** ________________

Date of Order: _______________________________________ **HT:** ___________IN. **WT:** _____________LBS.

1. **Y N** Is the use of an Air Fluidized Bed medically necessary for wound management?
2. **Y N** Is the patient bedbound or chairbound?
3. **Y N** Are you supervising the use of the AFT Bed through home health or wound care clinic?
4. **Y N** Do we need to provide this patient with a trapeze bar (E0910) with this bed?
5. **Y N** Do we need to provide this patient with a patient lift (E0630) with this bed?
6. **Y N** Does the patient have an advanced stage of coexisting pulmonary disease?
7. **Y N** Has this patient been on a group 2 support surface for at least 30 days without improvement?
8. **Y N** Has this patient had frequent repositioning (usually every 2 hours)
9. **Y N** Is the patient's current nutritional status adequate for wound healing? Specify daily intake: __________
10. **Y N** Is a trained adult caregiver available to assist the patient with daily living, fluid balance, skin care, repositioning, recognition and management of altered mental status, dietary needs, prescribed treatment and management support of the AFT Bed and any problems?
11. Have the Following wound care and instructions been provided during the past 30 days:
    - **Y N** Patient/Caregiver educated on the prevention and management of pressure ulcers?
    - **Y N** Turning and repositioning schedule followed?
    - **Y N** Incontinence/Moisture been managed? Method: ____
    - **Y N** Group 2 surface in use? Who provided and how long? ____
    - **Y N** Are moist dressings currently in use? Type of occlusive covering: _________________________________
    - **Y N** List conservative treatments tried prior to prescribing this bed: __________________________________

Ulcer Assessments	Ulcer #1	Ulcer #2	Ulcer #3
Location			
Stage			
L x W (cm)			
Depth (cm)			
Tunnel(s) (cm)			
Drainage Color & Amount			
Wound Bed Color			
Odor			
Age of Wound			
Date of Assessment			
Assessed By			
Wound Care Protocol			

I have reviewed the information contained on this form, and by signing below, I certify that the information is true, accurate and complete to the best of my knowledge.

Physician Signature: ____ **Date:** ________________________

Physician Name (Print): ____ **Date:** ________________________