

Email: [Healthinthehome@irishlifehealth.ie](mailto:Healthinthehome@irishlifehealth.ie) |

## Request for preauthorisation for the use of Negative Pressure Wound Therapy

Request form for pre-authorization for the use of Negative Pressure Wound Therapy – device only. Please note: this form is for out-patient negative pressure wound therapy where nursing care is provided independently (e.g. PHN). If nursing care and dressing changes are also required, please use the Health in the Home referral form instead.

### Hospital Details

|                      |  |
|----------------------|--|
| Requesting Clinician |  |
| Requesting Hospital  |  |
| Phone number         |  |
| Email                |  |

### Patient Details

|                                     |  |  |  |  |  |  |  |  |  |  |
|-------------------------------------|--|--|--|--|--|--|--|--|--|--|
| Name                                |  |  |  |  |  |  |  |  |  |  |
| Address                             |  |  |  |  |  |  |  |  |  |  |
| Phone Number                        |  |  |  |  |  |  |  |  |  |  |
| Date of Birth                       |  |  |  |  |  |  |  |  |  |  |
| Irish Life Health Membership Number |  |  |  |  |  |  |  |  |  |  |
| Proposed date to commence treatment |  |  |  |  |  |  |  |  |  |  |

### To be Completed by the Requesting Consultant

Please confirm the following:

|   | YES | NO |
|---|-----|----|
| Pressure Ulcer Stage III  |     |    |
| Pressure Ulcer Stage IV   |     |    |
| Venous or Arterial Insufficiency Ulcer  |     |    |
| Diabetic foot ulcer   |     |    |
| Complications of a surgically created wound (e.g. dehiscence)                               |     |    |
| Trauma wound or post-operative wound with a medical necessity for accelerated wound healing |     |    |

### Wound Information:

|                                   |     |    |  |
|-----------------------------------|-----|----|--|
| Wound location                    |     |    |  |
| Measurements (LxWxD)              |     |    |  |
| Is there tracking or undermining? | Yes | No |  |

### Negative Pressure Wound Therapy information :

|                                 |         |          |          |           |
|---------------------------------|---------|----------|----------|-----------|
| Type of treatment               | VAC     | SNAP     | Prevena  |           |
| Type of foam                    | Black   | White    | Silver   |           |
| Size of foam                    | Small   | Medium   | Large    |           |
| Potential Duration of Treatment | 1 Month | 3 Months | 6 Months | 6 Months+ |

|                                      |                                   |                      |                  |  |
|--------------------------------------|-----------------------------------|----------------------|------------------|--|
| Who will be completing the dressing? | Public Health Nurse               | Practice Nurse       | Returning to OPD | Community Tissue Viability Nurse (TVN) |
|                                      | Community Intervention Team (CIT) | Other- please state: |                  |  |

### Declaration

I hereby confirm that the Negative Pressure Wound Therapy Preauthorisation is being sought as an integral part of treatment and that the member has agreed to this treatment.

I confirm that the member also consents to this information being shared with third parties deemed necessary by Irish Life Health to carry out this treatment

I/we confirm that all the details, answers and information given in this form are true, accurate and complete. I/we confirm that I/we am/are giving my/our permission to you to use the information I/we have given on this form for the purposes set out in the Irish Life Health Privacy Notice which can be found at <http://www.irishlifehealth.ie/privacy-and-legal/privacy-statement/>

|                                   |  |  |  |  |  |  |  |  |  |  |
|-----------------------------------|--|--|--|--|--|--|--|--|--|--|
| Signature (requesting Consultant) |  |  |  |  |  |  |  |  |  |  |
| Date:                             |  |  |  |  |  |  |  |  |  |  |