V.A.C. Therapy Funding Review Form

AHSA FUND MEMBERS

Use this form for reviewing V.A.C. Therapy that has already commenced, where periodic reviews are required.

Member and Treating Doctor details:			
Member Name:	Member address:		
Health Fund: Membership number:	Contact number:	Date of Birth:	Gender:
Treating Doctor:	Phone: Fax	Date of application:	
Care Provider:	Phone: Fax:	Commencement of care (date):	
Is this patient being successfully treated with V.A.C. therapy in the community? **Yes / No**			
Please provide dates of initial and subsequent requests.			
How much longer is it estimated that treatment will take? Days/ Weeks			
What is the current dressing regime? Please describe including frequency of dressing changes.			
Do you consider that the current treatment regime is effective and if so why? **Yes / No**			

Wound details:
How has the wound changed since last report / review? • No change • Improved • Deteriorated • Other

Therapy Goal (endpoint): **(complete only if different from previous)**	**Please select:**	**Expected time frame (days/weeks)**
Surgical wound closure (post V.A.C. therapy)		
Wound closure / full epithelialisation		
Prepare wound bed for skin graft		
Application of skin graft		
Resolution of infection		
Palliative		
Exudate management		

Treatment Details:	
Frequency of review by doctor:	
Anticipated frequency of change of dressings:	
Anticipated number of visits per week by care giver (nurse)	

Wound Size:					
Length	mm	Width	mm	Depth	mm
Surface Area	cm^2	Volume	cm^3	Image taken	Yes /No

Wound Description: (please select)								
Wound Appearance	Sloughy		Infected		Necrotic		Granulation present	
Wound Bed color	Red		Yellow / sloughy		Black / Eschar			
Wound Edge	Viable		Rolled		Fibrotic		Closed	
Presence of	Undermining		Tunneling					
Peri wound appearance	Intact		Macerated		Denuded		Reddened	

Signature of treating doctor:		Date:
For Fund Use Only		
Approval for V.A.C. therapy		Yes / No
Review Period: e.g. fortnightly, 3 weekly	Frequency: Commencement date	
Treating Physician notified of Decision and details: Date:		Yes / No
Name and signature of Health Fund Assessor:		Date: