MISSOURI DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION
EXCEPTION PROCESS

AIR FLUIDIZED/LOW AIR LOSS THERAPY

FAX # 573-522-3061
TELEPHONE # 800-392-8030
PHARMACY/EXCEPTIONS UNIT
P.O. BOX 6500
JEFFERSON CITY, MO 65102-6500

PLEASE TYPE OR PRINT

ALL INFORMATION REQUESTED MUST BE PROVIDED. EXCEPTION FORM MUST ALSO BE COMPLETED.

PARTICIPANT	PARTICIPANT MO HEALTHNET NUMBER

THERAPY TYPE	DATE THERAPY STARTED	DATE PROJECTED TO STOP
☐ AIR FLUIDIZED ☐ LOW AIR LOSS	BRAND NAME	MODEL NUMBER

LOCATION OF USE

☐ HOME ☐ NURSING FACILITY NAME:

PHYSICIAN OR ADVANCED PRACTICE NURSE NAME	TELEPHONE NUMBER

ADDRESS

DIAGNOSIS

☐ PRESSURE ULCER ☐ FLAP ☐ GRAFT ☐ SURGERY/DATE _____

CO-EXISTING CONDITIONS			SPECIFY
☐ ABSENT	☐ CONTROLLED	☐ MODERATE ☐ ADVANCED	

MOBILITY

☐ AMBULATES INDEPENDENTLY ☐ AMBULATES WITH ASSIST ☐ ABLE TO REPOSITION ☐ BED CONFINED

PRESSURE ULCER LOCATIONS

PROGNOSIS FOR WOUND HEALING

EXPECTED LENGTH OF NEED (MONTHS) APPROVALS ARE SHORT TERM ONLY	DATE SKIN BREAKDOWN FIRST NOTICED
1 2 3	

PREVENTION METHODS USED (SPECIFY) IF NONE, GIVE REASONS

TREATMENTS TRIED, BUT SHOWN TO BE INEFFECTIVE/INAPPROPRIATE FOR USE AND WHY (INCLUDE TIME LENGTH OF PREVIOUS THERAPIES)

PREVIOUS AIR FLUIDIZED/LOW AIR LOSS THERAPY ☐ YES ☐ NO
DATES AND LENGTH OF TREATMENT

CURRENT WOUND TREATMENTS USED - DATES AND LENGTH OF TREATMENT

PERTINENT COMMENTS

DEBRIDEMENT

CHEMICAL/WHIRLPOOL	SURGICAL: DATES OF SURGERIES
DATE BEGIN DATE END	
HOURS OFF THERAPY PER DAY ☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ 5+	TURNING SCHEDULE FREQUENCY

DATE DIETARY CONSULT	RECOMMENDED CALORIC INTAKE	% OF RECOMMENDED DIET CONSUMED

NUTRITIONAL SUPPLEMENTS (INCLUDING NUMBER OF CANS/CALORIES PER DAY)

TPN THERAPY	TUBE FEEDING TYPE RATE

SERUM ALBUMIN	SERUM PREALBUMIN	SERUM TOTAL PROTEIN	SERUM Hgb/Hct
TEST DATE	TEST DATE	TEST DATE	TEST DATE

SKIN EXPOSURE TO URINE/FECES ☐ YES ☐ NO IF YES, METHODS OF CONTAINMENT

PRESENCE OF EDEMA/RECENT WEIGHT GAIN OR LOSS (SPECIFY)

WHO WILL PROVIDE THE WEEKLY WOUND CARE CONSULTATIONS DURING THERAPY? (NAME, TITLE, ADDRESS AND TELEPHONE NUMBER)

HAS PREVENTION PLAN BEGUN ☐ YES ☐ NO

DESCRIBE PREVENTION PLAN OF CARE

DESCRIBE POTENTIAL FOR BENEFIT AND HEALING

WEEKLY WOUND DESCRIPTIONS

SITE 1			SITE 2		
STAGE	LxW	DRAINAGE/OTHER	STAGE	LxW	DRAINAGE/OTHER

OTHER: E = Eschar O = Odor D = Drainage G = Granulation H = Healed

PHYSICIAN OR ADVANCED PRACTICE NURSE SIGNATURE ▶	DATE
PRINT PHYSICIAN OR ADVANCED PRACTICE NURSE NAME AND TITLE	FAX NUMBER