



Need by date and time: _____

Please email or fax to the following:
smith-nephew@sunmedmedical.com or fax to (856)-242-2390
If you have questions Call: (888)-205-7511

Requester and Post-Acute Clinical Provider Information: Please complete in full

Requester Facility Information: Requester Name: _____ Title: _____
 Requester Facility Name: _____ Phone # _____ Fax # _____
 Address: _____ City: _____ State: _____ Zip: _____
 Requester Email Address: _____

Delivery Location: Home Facility/RM#: _____ Other: _____
Delivery Address: _____ City: _____ State: _____

Post-Acute Provider or Home Health administering Dressing Changes: Name: _____
 Phone # _____ Address: _____ City: _____ State: _____ Zip: _____

Supplies for Delivery: Please check the RENASYS® Dressing(s) requested

RENASYS Foam with Soft Port: Small Medium Large
 RENASYS Gauze with Soft Port Medium
 Other Supplies (Y-connectors, film, ACTICOAT, gel patch): _____ White foam _____

Patient Information: Please also submit demographic and/or insurance sheet

Patient Name (print) Last: _____ First: _____ MI: _____ D.O.B.: ____/____/____
 Email: _____ Phone: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Emergency Contact (if available): _____ Phone: _____
 Primary Insurance: _____ Policy # _____ 2nd Ins. _____ Policy # _____

Wound #1 Type _____	Wound #2 Type _____
Age in Months: _____	Age in Months: _____
Wound Location: _____	Wound Location: _____
Length: _____ cm Width: _____ cm Depth: _____ cm	Length: _____ cm Width: _____ cm Depth: _____ cm

Prescription Information: Complete in full or fax written prescription to include the following

I prescribe Smith+Nephew RENASYS Therapy for the following wound type(s):
 Pressure Ulcer(s) Diabetic Ulcer(s) Venous Ulcer(s) Arterial Ulcer Surgically Created Other: _____
 Provide narrative description specifying wound etiology and including anatomical location(s): _____

I prescribe Smith+Nephew RENASYS Therapy for: 1 month 2 months 3 months 4 months Other(weeks) _____ and
15 RENASYS therapy dressings with soft port per wound and 10 RENASYS therapy canisters per month.
 Additional cannisters required for excessive drainage 5 cannisters 10 cannisters
 Additional dressings required for Infected wound Multiple wounds Other _____ 5 Dressings 10 Dressing
 Order date of Homecare RENASYS Therapy: ____/____/____
 RENASYS EDGE pressure setting: 80mmHg 100mmHg 125mmHg Other _____
 Goal at the completion of Smith+Nephew RENASYS Therapy:
 Assist in granulation tissue formation Flap Graft Delayed Primary closure (tertiary)

Prescriber Information. Prescriber Only to Complete. Original Signature Required. No Stamps.

Prescriber Name (print) Last: _____ First: _____ MI: _____ NPI# _____
 Phone: _____ Fax: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Email: _____
 Prescriber Signature: _____ Date: ____/____/____
 By signing and dating, I attest that I am prescribing the Smith+Nephew RENASYS Negative Pressure Wound Therapy System (DO NOT SUBSTITUTE) as medically necessary, and all other applicable treatments have been tried or considered and ruled out. I have read and understand all safety information and other instructions for use included with the RENASYS Therapy product, as well as the Smith+Nephew RENASYS Therapy Clinical Guidelines. I also understand the Smith+Nephew RENASYS Therapy System contraindications.

Comments/Special Requests
