SunMED Medical Solutions

Please email this demographic form to **smith-nephew@sunmedmedical.com** or fax to (856) 242-2390 If you have any question, please call (888) 205-7511

(1) Patient Information (Important: Please submit demographic and/or insurance sheet)

Patient Name (print) Last: _____ First: _____ MI: _____ Patient DOB: ___ /__ /____
(skip completing patient's home address if demographic/insurance sheet submitted) Patient Email: _____
Home Address:_____ Apt #: _____
City: _____ ST: _____ Zip Code:_____ Phone #: _____
Emergency Contact (if available): _____ Phone #: _____
Primary Insurance _____ Policy# _____ 2nd Ins._____ Policy# _____

(2) Prescriber Information (Complete in full or fax written prescription to include the following)

I prescribe SMITH AND 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 AND NEPHEW RENASYS EDGE Therapy for: ☐ 1 month ☐ 2 months ☐ 3 months ☐ 4 months ☐ Other(weeks) _____
and up to 15 RENASYS Therapy dressings per wound and up to 10 RENASYS Therapy canisters per month.

Order date of HOMECARE RENASYS Therapy: ___/___/____ Pressure Setting: ☐ 80mmHg ☐ 100mmHg ☐ 125mmHg ☐ Other:_____
Goal at the completion of SMITH AND NEPHEW RENASYS Therapy:

☐ Assist in granulation tissue formation ☐ Flap ☐ Graft ☐ Delayed Primary closure (tertiary)

Treating prescriber name (print) Last: _____ First: _____ MI: _____

Address: _____City: _____ ST: _____ Zip: _____

Prescriber Phone: _____ Fax: _____ Email: _____NPI: _____

Request an electronically signed prescription from Prescriber *(please provide Prescriber's email address)*

Prescriber Only to Complete Original Signature Required. No Stamps

Prescriber Signature:_____Date:____/__/_____

By signing and dating, I attest that I am prescribing the SMITH AND 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 AND NEPHEW RENASYS Therapy Clinical Guidelines. I also understand the SMITH AND NEPHEW RENASYS Therapy System contraindications.

(3) Requestor & Post-Acute Clinical Provider Information (Please complete in full)

Requestor Facility Information Requestor Name: _____ Title: _____
Requestor Facility Name: _____ Phone: _____ Fax: _____
Address: _____City: _____ ST: _____ Zip: _____
Check here to be emailed a link to status information on this order Email Address for Status link: _____

Delivery Location: ☐ Home ☐ Facility/ RM#: _____ ☐ Other: _____
Delivery Address: _____City: _____ State: _____ Zip: _____
Need By Date: ___/___/____ Need By Time: _____:_____

SMITH AND NEPHEW RENASYS Therapy System will be used in what type of facility:
☐ Private Residence ☐ WCC ☐ SNF ☐ LTAC / Rehab ☐ Assisted Living ☐ Other: _____
Post-Acute Clinical Provider administering Dressing Changes: Name _____ Ph. _____
Address: _____City: _____ ST: _____ Zip: _____

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

RENASYS Foam with Soft Port ☐ Small ☐ Medium ☐ Large Other Supplies (Y-connectors, etc.): _____

RENASYS Gauze with Soft Port ☐ Medium

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Patient Name: _____ D.O.B.: ____/____/_____ Completed by: _____

(5a) Patient's Primary Wound Type

Pressure Ulcer: Stage III Stage IV

1. Is the patient being turned/positioned? ☐ Yes ☐ No
2. Has a group 2 or 3 surface been used for ulcer located on the posterior trunk or pelvis? ☐ Yes ☐ No
3. Are moisture and/or incontinence being managed? ☐ Yes ☐ No
4. Is pressure ulcer greater than 30 days? ☐ Yes ☐ No

Diabetic Ulcer/Neuropathic Ulcer:

1. Has a reduction of pressure on the foot ulcer been accomplished with appropriate modalities? ☐ Yes ☐ No

Venous Stasis Ulcer/Venous Insufficiency:

1. Are compression bandages and/or garments being consistently applied? ☐ Yes ☐ No
2. Is elevation/ambulation being encouraged? ☐ Yes ☐ No

Arterial Ulcer/Arterial Insufficiency:

1. Is pressure over the wound being relieved? ☐ Yes ☐ No

Surgical

1. Was the wound surgically created and not represented by descriptions above? ☐ Yes ☐ No
2. Description of surgical procedure. _____
3. Date of surgical procedure involving wound. _____/_____/_____

Other Wound Type (describe): _____

Please Complete if Applicable
Is wound a direct result of an accident?
☐ Yes ☐ No

If Yes, complete the following:
Date of accident: ___ /___/ _____

Accident Type:
Auto Employment ☐ Trauma

(5b) Wound(s) Description

Wound #1 Type: _____ Age in Months: _____
Wound Location: _____
Is there eschar tissue present in the wound? ☐ Yes ☐ No
Has debridement been attempted in the last 10 days? ☐ Yes ☐ No
If Yes, debridement date: ____/_____/_____
Debridement type:
Are serial debridements required? ☐ Yes ☐ No
Measurement date: ____/_____/_____
Length: _____ cm Width: _____ cm Depth: _____ cm
Appearance of wound bed and color: _____
Exudate (amount and color): _____
Is the wound full thickness? ☐ Yes ☐ No
Is muscle, tendon or bone exposed? ☐ Yes ☐ No
Is there undermining? ☐ Yes ☐ No
Location #1: _____cm, from _____to_____ o'clock
Location #2: _____cm, from _____to_____ o'clock
Is there tunneling/sinus? ☐ Yes ☐ No
Location #1: _____cm, from _____to_____ o'clock
Location #2: _____cm, from _____to_____ o'clock

Wound #2 Type: _____ Age in Months: _____
Wound Location: _____
Is there eschar tissue present in the wound? ☐ Yes ☐ No
Has debridement been attempted in the last 10 days? ☐ Yes ☐ No
If Yes, debridement date: ____/_____/_____
Debridement type:
Are serial debridements required? ☐ Yes ☐ No
Measurement date: ____/_____/_____
Length: _____ cm Width: _____ cm Depth: _____ cm
Appearance of wound bed and color: _____
Exudate (amount and color): _____
Is the Is the wound full thickness? ☐ Yes ☐ No
Is muscle, tendon or bone exposed? ☐ Yes ☐ No
Is there undermining? ☐ Yes ☐ No
Location #1: _____cm, from _____to_____ o'clock
Location #2: _____cm, from _____to_____ o'clock
Is there tunneling/sinus? ☐ Yes ☐ No
Location #1: _____cm, from _____to_____ o'clock
Location #2: _____cm, from _____to_____ o'clock

(5c) Clinical Information by Wound Type

1. Was NPWT initiated in an inpatient facility? Yes No Date Initiated: ____/____ /_____
   OR has the patient been on NPWT anytime during the last 60 days? Yes No Facility Name: _____
2. Is the patient's nutritional status compromised? Yes No Facility City, St: _____

If Yes, check the action taken: Protein Supplements Enteral/NG Feeding TPN Vitamin Therapy ☐ Special Diet

3. Indicate other therapies that have been previously tried and/or failed to maintain a moist wound environment:
   Saline Gauze Hydrogel Alginate Hydrocolloid Absorptive None Other: _____
4. If other therapies were considered and ruled out, what conditions prevented you from using other therapies prior to applying RENASYS Therapy?:
5. Presence of co-morbidities High risk of infections Need for accelerated granulation tissue ☐ Prior history of delayed wound healing
   Other, please describe: _____
6. Which of the following co-morbidities apply? Diabetes Immobility Immunocompromised ESRD ☐PVD ☐PAD ☐Obesity ☐Smoking ☐ Depression ☐N/A
7. If above diabetes box checked, is the patient on a comprehensive diabetic management program? ☐ Yes ☐ No ☐ N/A
8. Is Osteomyelitis present in Wound? Yes No If Yes, please indicate the following:
   Antibiotic(list name) _____ IV Antibiotics (list name) _____ ☐ Hyperbaric Oxygen
   Is the above treatment administered to the patient with the intention to completely resolve the underlying bone infection? ☐ Yes ☐ No
9. Please provide a short narrative of possible consequences if RENASYS Therapy is not used. **(Please include/attach any clinical data such as H&P, OP report, and other medical documentation supporting treatments tried and describing factors impacting wound healing):** _____
   _____