

Order and prescription form:
Fax: 866-304-6692

Patient Assistance Program:
Phone: 866-988-3491

PLEASE NOTE: ADDITIONAL DOCUMENTATION REQUIRED! PLEASE FAX THE PATIENT'S FACE SHEET AND APPLICATION WITH THIS FORM.

Patient information:

First and last name:	DOB:
Address:	
Phone:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Do you currently have public or private insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Are you a U.S. Military Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Financial information: (if any items is \$0, please indicate \$0 – do not leave blank)	
Total annual household income:	Number in household: (to include spouse, legal guardian and dependent)
Extraordinary medical expenses:	
Explanation of extraordinary medical expenses:	
Additional considerations for receiving patient:	
<hr/>	<hr/>
Patient or legal guardian signature	Date
Printed name if legal guardian	
<small>I understand the above information is being provided to Smith+Nephew, Inc., or its assigned agent, with the intent of receiving financial assistance for the Negative Pressure Wound Therapy I have been prescribed. I understand that Smith+Nephew, Inc. has the right to verify this information and to request additional proof or documentation. I authorize Smith+Nephew, Inc. to use and/or disclose this information to verify if I am eligible to participate in the patient assistance program and understand that such verification may include contacting me, my physician and affiliated healthcare personnel, and/or any current insurance provider for additional information. I further understand that based on a review of the information provided, I may still have a financial liability (e.g. office visit copay). I swear, or affirm that the above information is true and correct to the best of my knowledge.</small>	

Pressure ulcer(s) Diabetic ulcer(s) Venous ulcer(s) Arterial Surgical Other

Wound location: Length: _____ Width: _____ Depth: _____

Dressing kit type: Foam Gauze **Dressing size:** Small Medium Large

Other supplies: Y connector White foam Transparent film

I prescribe therapy for: 1 month** 2 months** 3 months** **Diagnosis:** _____

**Please Note: Each prescription is limited up to a 3 month supply, up to 15 dressings per wound and up to 10 canisters per month (unless otherwise specified). A separate request will need to be submitted if additional product is required beyond the initial request.

Licensed HHA or provider that will manage the patient's outpatient wound care: _____

Phone: _____

Delivery Address: (Please do not use a PO Box; for RENASYS delivery to hospital; include the patient's room number and discharge point of contact)

Home Hospital, Room#: _____

Clinic

Date needed/Discharge date: _____

Provider information: ORIGINAL SIGNATURE AND DATE REQUIRED

Facility name:	Date:
Full address:	
Phone:	Fax:
	NPI#:
<small>By signing and dating, I attest that the person listed above is my patient for whom I have prescribed the Smith+Nephew NPWT system as medically necessary. I have read and understand all safety information and other instructions for use included with therapy clinical guidelines. I further certify that I have received the necessary written authorization to release the medical and/or other patient eligibility for the assistance program.</small>	
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Treating prescriber name printed	Date
Referral contact name:	Phone:
	Treating prescriber signature