RENASYS◇GO and PICO◇

Negative Pressure Wound Therapy Systems

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.

1. Patient Information

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Delivery Date: _____

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

_____

Licensed home health agency *or* provider that will manage the patient's outpatient wound care:

_____ Phone: _____

2. Prescriber Information: ORIGINAL SIGNATURE AND DATE REQUIRED.

Facility Contact Name: _____

Phone Number: _____ Fax Number: _____

Treating Prescriber (Print) Last Name: _____

First Name: _____

Treating Prescriber Signature: _____ Date: _____

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 information referenced on this form and agree that Smith+ Nephew, Inc., or its assigned agent, has the right to contact the patient directly to gather additional information for the purposes of verifying eligibility for the assistance program.

Facility Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ NPI#: _____

3. Wound Information: Wound diagnoses codes are **required** and should be listed to include the specific anatomical site, type of wound, and etiology whenever possible.

Wound Type: ☐ Chronic Pressure Ulcer ☐ Diabetic/Neuropathic Ulcer ☐ Venous Stasis Ulcer ☐ Traumatic/Surgical Wound ☐ Other: _____

Wound #1 Measurements: Length_____cm Width_____cm Depth_____cm

Wound #2 Measurements: Length_____cm Width_____cm Depth_____cm

Diagnoses: _____ **Wound Location(s):** _____

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Please complete the order information for *either* PICO *or* RENASYS GO

4a. PICO◇ Ordering Information

Current Exudate Level: _____ Low _____ Moderate or _____mL/day

Please provide PICO Single Use NPWT System of specified size:

- ☐ 4"x8" (10cm x 20cm)
- ☐ 4"x12" (10cm x 30cm)
- ☐ 4"x16" (10cm x 40cm)
- ☐ 6"x6" (15cm x 15cm)
- ☐ 6"x8" (15cm x 20cm)
- ☐ 6"x12" (15cm x 30cm)
- ☐ 8"x8" (20cm x 20cm)
- ☐ 10"x10" (25cm x 25cm)

I prescribe NPWT therapy for: ☐ **3 weeks*** ☐ **6 weeks***

*Please Note: Each prescription is limited up to a 6 week supply; a separate request will need to be submitted if additional product is required beyond the initial request.

4b. RENASYS◇GO Ordering Information

***REQUIRED: Supplies for Delivery with RENASYS Negative Pressure Wound Therapy**

Dressing kit type:	☐ Gauze	☐ Foam	
Dressing kit size:	☐ Small	☐ Medium	☐ Large
Canister size:	☐ 300mL		
Other supplies:	☐ Extra Transparent Film	☐ Y Connector	

I prescribe NPWT therapy for: ☐ **1 month**** ☐ **2 months**** ☐ **3 months****

**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.

For detailed product information, including indications for use, contraindications, effects, precautions, warnings and important safety information, please always consult the product's Instructions for Use (IFU) prior to use.

Advanced Wound Management
Smith & Nephew, Inc.
Fort Worth, TX 76109
USA

Customer Care Center
1-800-876-1261
T 727-392-1261
F 727-392-6914

www.smith-nephew.com

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