SunMED Medical Solutions

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 _____

Age in Months:_____

Wound Location: _____

Length:_____cm Width:_____cm Depth: _____cm

Wound #2 Type _____

Age in Months:_____

Wound Location: _____

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