Negative Pressure Wound Therapy System
Patient Assistance Program Application

Negative Pressure Wound Therapy

Patient Assistance Program:
PHONE: 205-942-2650

Please complete this form and fax it to 942-5094

Section 1	Patient Personal Information		
Last Name:	First Name:		MI
DOB:	Phone:	☐ Home ☐ Work ☐ Mobile	
Mailing Address:			
City:	State:	Zip:	
Gender: ☐ Male ☐ Female	Are you a U.S. military veteran? ☐ Yes ☐ No		
Do you currently have any public or private insurance? ☐ Yes ☐ No			

Section 2	Financial Information (if any item is $0, please indicate $0 – do not leave blank)
Total Annual Household Income:	$
Number in Household: (to include spouse, legal guardian and dependents)	
Extraordinary Medical Expenses:	$
Explanation of Extraordinary Medical Expenses:	
Additional Considerations for Receiving Patient Assistance:	

Section 3	Consent
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 to use and/or disclose this information to verify if I am eligible to participate in the 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. I swear, or affirm that the above information is true and correct to the best of my knowledge.	
Patient Signature	Printed Name of Legal Guardian
Date	Signature of Legal Guardian

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

RENASYS◊ and PICO◊
Negative Pressure Wound Therapy Systems

Order and Prescription Form
Fax this form to 942-5094

smith&nephew

Patient Assistance Program: PHONE: 942-2650
S&N Hotline 888-705-0061

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

Patient Personal Information

Last Name: _____ First Name: _____ MI: _____

DOB: _____ Delivery Date: _____

Delivery Address: (*No PO Box and for RENASYS delivery to hospital, include patient room #*): _____

_____

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

_____ Phone:_____

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 #:_____

Wound Information

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

Wound #1Measurements: Length_____cm Width_____cm Depth_____cm

Wound#2 Measurements: Length _____cm Width_____cm Depth_____cm

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

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Please complete the ordering information for either PICO or RENASYS

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 20 cm) ☐ 6"x12" (15cm x 30cm)
☐ 8"x8" (20cm x 20cm) ☐ 10"x10" (25cm x 25cm) ☐ Multisite 6"x8" (15cm x 20cm)
☐ Multisite 8"x10" (20cm x 25cm)

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

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

RENASYS 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* ☐ *Other (please specify duration)* _____

** Please note that 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 prescription will need to be submitted if additional product is required beyond the initial request.*

Prescriber Initials: _____ *Date:* _____

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
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