

**Request for  
Additional Supplies**

**Please include copies of all pertinent information from patient's medical record to validate the information provided here.**

**PATIENT INFORMATION** [Complete this section ONLY if you will not be supplying a Face Sheet that contains this information.]

Patient's Name (Last, First, MI): \_\_\_\_\_

Patient's DOB:      /      /           SS#      -      -       
mm      dd      yyyy

**JUSTIFICATION FOR ADDITIONAL SUPPLIES**

- Wound size exceeds the largest available dressing set
- Dressing changes are required more often than 48-hours (please explain below)
- Wound is heavily draining beyond capacity of largest canister in a 3-day period
- Other (please explain in detail) \_\_\_\_\_

Due to the above, please have a customer service representative contact me regarding additional supplies:

Contact Name: \_\_\_\_\_

Title: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Alternate Phone Number: \_\_\_\_\_

**TO BE COMPLETED BY PRESCRIBER**

**PRESCRIPTION, ATTESTATION AND PRESCRIBER INFORMATION**

I attest that Patient, \_\_\_\_\_, needs additional supplies (beyond the initially supplied 15 dressing sets and 10 canisters per month) for the proper administration of negative pressure wound therapy with Invia® Wound Therapy. This request is being made for the reasons defined above:

Prescriber's Signature \_\_\_\_\_ Date      /      /       
mm      dd      yyyy

Prescriber's Name [print] (last) \_\_\_\_\_ (first) \_\_\_\_\_ (mi) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ NPI: \_\_\_\_\_