SYNCHROMED II PUMP ORDER FORM

Required Information

Hospital / Clinic / Distributor Name ______________________

Address ______________________

City ______________ Postal Code ______________

District / Province / Region / State ______________ Country ______________

Delivery Date ______________ Delivery Time (optional) ______________

Order Type (check one)

☐ Hospital / Clinic / Distributor Purchase
→ Provide Purchase Order Number ______________ →

OR

☐ Hospital / Clinic Consignment
→ Provide Purchase Order Number (optional) ______________ →

OR

☐ Ship to Medtronic Rep
→ Rep Name or Rep Account Number ______________ →

Note: Please confirm delivery date with Medtronic Rep.

Quantity

☐ 20 mL 8637-20

☐ 40 mL 8637-40

Additional Products / Ship Attention / Special Instructions (optional)

Physician Email (optional) ______________________

Carrier Preference (optional) ______________________

Please submit this order form with a signed certificate for each pump ordered by either faxing or scanning and emailing to Medtronic Customer Service. If needed, contact Medtronic Customer Service for assistance.

Medtronic Customer Service Contact Info ______________________

For additional information, please refer to **www.facts.synchromed.com**

For Medtronic Internal Use Only

Complete this section only if using a Backup Only pump

Serial Number | N | G | | | | | | | | H |

☐ EMERGENCY USE – Check this box ONLY if this SynchroMed pump was provided to the physician prior to obtaining their signature due to an emergency situation.

UC201503749 EE

Medtronic

CERTIFICATION OF MEDICAL NECESSITY SYNCHROMED® DRUG INFUSION PUMP

To be completed by the patient's physician

I have received and reviewed the notification from Medtronic Neuromodulation regarding the agreement (Decree) between Medtronic and the U.S. Food and Drug Administration (FDA) concerning the manufacture and distribution of the SynchroMed drug infusion system.

I have discussed this agreement with my patient. Based on my consideration of the patient's condition during my medical evaluation, I have determined, in my professional judgment, that the SynchroMed drug infusion pump is medically necessary to treat the patient's condition and that the benefits of such treatment outweigh the risks.

From the list below, please indicate the medical condition that requires treatment with the SynchroMed drug infusion pump.

The patient suffers from:

- ☐ Chronic intractable pain
- ☐ Severe chronic pain
- ☐ Severe spasticity
- ☐ Primary or metastatic cancer

_______________________________	_______________________________
Physician Signature	Date
_______________________________	_______________________________
Physician Name (printed)	Contact Number