

University of Kentucky

New / Replacement Technology Request Form

1. All questions must be answered completely, and signatures obtained.

2. Return completed form to:

Lorra Miracle, RN, Value Analysis/PI Facilitator
N-100, Hospital Administration
Phone # 3-4745, FAX# 3-2044, Pager #2706

TO BE COMPLETED BY REQUESTING PHYSICIAN

Name of Product(s): _____

Manufacturer: _____ Manufacturer Catalog #: _____

Suggested Vendor: _____ Vendor Quote: _____

Briefly describe the product (also, describe other required components / accessories if applicable):

What effect will this product have on the following: (choose all that apply and briefly explain)

- a. Quality of patient care:
- b. Patient and or employee safety:
- c. Physician and staff satisfaction:
- d. Expense: (increase or decrease)
- e. Operational efficiency
- f. Education and research:
- g. Other:

Is there a product in-house now performing the same function?

YES NO

If YES, what product(s) performs the same function as the requested product? (Description & manufacturer)

Where will this product be used? (Inpatient or outpatient)

Is product FDA approved? Yes No



If No, how is product currently classified by FDA, i.e. B3, etc.? _____

What procedures will be performed with this product? Be specific, i.e. CPT, ICD-9

Will this product be used on all of the above procedures or a subset of these patients with specific considerations or complications? Please explain. _____

What is the anticipated procedure/product usage volume? _____

Who will perform these procedures? (physician etc. specific) _____

Do you anticipate other department(s) using and/or being affected by this product? Yes No

If Yes; Explain and identify the affected parties: _____

How did you find out about this product? (mark all that are applicable)

_____ Prior experience with product _____ Trade Show _____ Contract Review
_____ Sales Rep came to department _____ Other (specify) _____

Sales Representative's name: _____

Sales Representative's phone number and e-mail: _____

Please attach manufacturer's specifications, reimbursement info, sales literature, and representative's business cards.

Please attach research articles.

Conflict of Interest Statement

Departments/Physicians requesting products for admission to the formulary must complete this conflict of interest statement. This information is shared with Committee members and is considered when discussing your request. A potential conflict of interest issue does not disqualify someone from requesting a product. The Committee recognizes many departments and members of the Medical Staff have relationships with manufacturing companies. Physicians with expertise in an area have often received research grants or other support from companies. However, the Committee feels it is important to disclose these relationships.

Currently or in the past have you, your department, or family member had a proprietary interest in this product or associated company? YES NO

If YES, which company(ies):



Please check all that apply:

- Own stock in one of the above companies (excluding mutual funds)
- Serve on the board of directors for one of these companies
- Expect to receive (or currently receive) royalties from one of these companies
- Other _____

Has department/you received any financial support from the companies listed? YES NO

If YES, which company(ies)?

Please check all that apply:

- Received funding for research
- Received support for presenting continuing medical education or other professional education programs supported by the company
- Received an educational grant
- Received travel support
- Other _____

Additional Comments:

Name of Requesting Party: _____

Department: _____ Date: _____

Facility: _____ Phone #: _____

Signature: _____

Please attach supporting documentation that can assist the Technology Assessment Committee in its review of this product, technology or service.

If you have any questions or would like to discuss your request, please contact:

Richard W. Schwartz, MD, MBA
 Professor of Surgery
 Chair, Interventional Units Team
 323-6346, Ext. 237; Pager #259-6610
 rschw01@pop.uky.edu

or

Lorra Miracle, RN
 Value Analysis/PI Facilitator/UHC Liaison
 N-100, Hospital Administration
 323-4745, Pager #2706
lmira0@pop.uky.edu

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TO BE COMPLETED BY INTERVENTIONAL UNITS TEAM

1. Is the requested product(s):

Under a current contract? YES NO

If YES, please specify: Novation UK Contract Expiration Date: _____

2. Price Quote for New Product _____

3. Date Reviewed: _____ Date for Physician Presentation: _____

4. Will there be additional implementation costs, such as installation, cost of education, impact on equipment, additional space?

If YES, please describe:

4. Notes:

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