

Request Form for Custom-made medical device

Serial number

Bronchial stent

Hospital name

Prescribing physician name

Stent details (all fields are mandatory)

Type of stent General information Please tick all that apply	Biodegradable, uncovered, tubular		
Stent dimensions [mm]	Diameter:	Length:	
	Maximum stent length after deployment:		
Radiopaque markers	<input type="checkbox"/> Proximal end	<input type="checkbox"/> In the middle of the stent	<input type="checkbox"/> Distal end
Delivery system	Diameter [F]:	Length [cm]:	<input type="checkbox"/> 45 <input type="checkbox"/> 60 <input type="checkbox"/> 70
Other specification for stent and delivery system			
Identification of patient			
Age of patient			

Patient details (all fields are mandatory)

Indication	<input type="checkbox"/> Postinflammatory stenosis Please specify:		
	<input type="checkbox"/> Congenital bronchomalacia		
	<input type="checkbox"/> Congenital heart defect and/or the great vessels defect Please specify:		
	<input type="checkbox"/> Postsurgical stenosis	Reason for the surgery	
	Tumor stenosis <input type="checkbox"/> Extraluminal <input type="checkbox"/> Intraluminal	<input type="checkbox"/> Lung transplant <input type="checkbox"/> Other:	
	<input type="checkbox"/> Leak	<input type="checkbox"/> Fistula	<input type="checkbox"/> Other specification:
Length of stenosis [mm]			
Location of stenosis or lesion	<input type="checkbox"/> Left main bronchus		<input type="checkbox"/> Right main bronchus
	<input type="checkbox"/> Left upper lobar bronchus		<input type="checkbox"/> Right upper lobar bronchus
	<input type="checkbox"/> Left lower lobar bronchus		<input type="checkbox"/> Right middle lobar bronchus
			<input type="checkbox"/> Right lower lobar bronchus

Original diagnosis		
Treatment history Please detail all treatment(s), procedures & management to date, maximum dilation achieved (if dilated) & potential associated risks, etc.	Previous stent implantation <input type="checkbox"/> Yes <input type="checkbox"/> No Type of the stent: Number of implantations: Dates of implantations: Surgery <input type="checkbox"/> Yes <input type="checkbox"/> No Specify: Dilation <input type="checkbox"/> Yes <input type="checkbox"/> No Number: Dilation up to [mm]:	Other specification:
Reason for using this stent Please include potential benefits & risks to patient		

PRE-0046-P02_EN/02

Please note that this non-official form is designed to describe the requirements of a customer which is necessary for assessment of general safety and performance requirements according to MDR 2017/745. After confirming the availability of requested product, an official **Prescription form** shall be issued.

The **Prescription form** is an official document strictly required before dispatch of any custom-made medical device!

Please note that the stent pitch numbers, thread diameter and thread crossing angle of custom made stents can cause a length tolerance of +/- a few mm but we will manufacture the stent as accurate as possible