

Request Form for Custom-made medical device			Serial number		
Tracheal stent					
Hospital name		Prescribing physician name			
Stent details (all fields are mandatory)					
Type of stent General information Please tick all that apply	<input type="checkbox"/> Biodegradable uncovered <input type="checkbox"/> Nitinol covered <input type="checkbox"/> Tubular				
Stent dimensions [mm]	Diameter:		Length:		
	Maximum stent length after deployment:				
Radiopaque markers – Specify quantity	<input type="checkbox"/> Proximal end Quantity:	<input type="checkbox"/> In the middle of the stent Quantity:	<input type="checkbox"/> Distal end Quantity:		
Delivery system	Diameter [F]:		Length [mm]:		
	<input type="checkbox"/> Olive tip		<input type="checkbox"/> Balloon catheter		
Other specification for stent and delivery system					
Identification of patient					
Age of patient					
Patient details (all fields are mandatory)					
Indication	<input type="checkbox"/> Stenosis post-intubation <input type="checkbox"/> Congenital tracheomalacia <input type="checkbox"/> Post-surgical stenosis <input type="checkbox"/> Anastomotic stenosis		<input type="checkbox"/> Stenosis post-tracheostomy <input type="checkbox"/> External vascular compression Tumor stenosis <input type="checkbox"/> Extraluminal <input type="checkbox"/> Intraluminal		
	Reason for surgery:				
	<input type="checkbox"/> Leak		<input type="checkbox"/> Fistula		
	<input type="checkbox"/> Other specification:				
	Length of stenosis [mm]				
	Location of stenosis or lesion	Distance from the vocal cords [mm]:	<input type="checkbox"/> Upper trachea	<input type="checkbox"/> Middle trachea	<input type="checkbox"/> Lower trachea

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		

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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.