Medical prescription: drainova® and PleurX™ drainage systems

ewimed

This patient has received a drainova® or PleurX™ catheter. We are registering him/her for initial instrcution about how to carry out a recurrent drainage with dressing change. Please supply the patient with the prescribed drainage material and arrange the appointment for the drainage instruction.

Please send the complete prescription to: ewimed@hin.ch
The orginal prescription goes to the patient at discharge.

Patient label/ Address and date of birth

Implanted on: _____ ○ outpatient

Hospital (prov. departure date): _____

1 Medical information & drainage recommandation

Catheter position: ○ Pleura left ○ Pleura right ○ Ascites

Drainage vol. postop: _____ ml

Interval recomm. ○ postop. each day during 2 week / thereafter, symptomatic

or

Interval recomm.: ○ approx. _____ X weekly

Pneumothorax: ○ yes ○ no ○ indicated permanent drainage

Remarks:

Mandatory field

Health insurance / Insurance number or AHV number

SUVA/Claim number

Catheter lot number / adhesive label

2 Prescription (mark relevant article with ☒):

Article name/PU	Art.no.:	MiGeL no.:
☐ drainova® clickFix	P1100S	01.03.02.02.1
☐ drainova® rinsing tube	6060/2	01.03.02.01.1

Long term prescription for drainova®-, ewimed or PleurX™ drainage sets

☐ Drainage by soft vaccum 2000 ml	1 PU = 10 pieces	2010	01.03.01.01.1
☐ Drainage by gravity 2000 ml	1 PU = 10 pieces	50-7505	01.03.01.01.1
☐ Drainage by vacuum 1000 ml	1 PU = 10 pieces	50-7510	01.03.01.01.1
☐ Drainage by vacuum 500 ml	1 PU = 10 pieces	50-7500B	01.03.01.01.1

3 Attending physician(s) / hospital / clinic:

a) Prescribing physician: (Implanting clinic): _____

Phone: _____

Date of prescription & signature physician: _____ ✘ _____

Date Signature physician

Stamp hospital / clinic

If this form is not directly signed by the patient himself, the prescribing doctor shall confirm that the patient's consent has been obtained in accordance with point 7.

4 Aftercare:

a) Family member / Name: _____ Phone: _____

b) Spitex / Nursing home / Hospice / Clinic/ Hospital / Rehabilitation centre

Name: _____ Phone: _____

Address: _____

5 Material order, advice & instruction by:

ewimed Switzerland AG • Freiburgstrasse 453 • CH-3018 Bern • Phone +41 31 958 66 66 • ewimed@hin.ch

6 Data protection notice for the patient:

ewimed Switzerland AG („ewimed") processes your data in order to supply you with the adequare drainage material and to instruct you and any third parties assisting you in its use, such as nursing services.

Your data will only be passed on to third parties in exceptional cases

If you would like to know more about this present and the general processing of data by ewimed, further information can be found in our specific data protection declaration by using the following link:

https://ewimed.ch/en/privacy-policy/

7 Patient's consent to the transfer of data:

I hereby declare that the attending physician, the hospital or the clinic may transfer my personal data to ewimed and that the latter may forward this data to care services, KESB or other third parties as described in point 6.

Your data includes general information about you (e.g. name, address, date of birth, health insurance), and in particular, information about your health (drainage quantitiy, infections, diagnosis, visit protocols, etc.), which are personal data considered under the data protection legislation the requires special protection. Your data will be passed on to third parties only in exceptional cases, if you have consented to this or if this is necessary for the execution of the contract, provided by law or is required on the basis of an overriding private or public interest, such as third parties appointed by you or the authorities to support you, such as relatives, guardians or care services, to the Child and Adult Protection Authority (KESB), via MediData to health insurance funds and insurance companies, insurances, as far as necessary for the settlement of accounts or, in the case of payment arrears, to the responsible or other authorities.

Date: _____ Patient signature: ✘ _____