

NEW PRODUCT REQUEST DATA SHEET

SMAT Committee

Cartersville Medical Center

- 1. Please complete this form **Prior** to ordering supplies and/or equipment, which have NOT been ordered before. All areas must be completed. **Any requests not completed properly will be returned to the requesting department.**
- 2. Submit this form to the CRD at least ten days prior to the SMAT meeting for any costing or vendor information, and to be placed on the SMAT agenda. It is the Department Director's responsibility to bring both completed forms and product information to the **Supply Management Action Team** meeting to present the product. Appropriate Department Director and Senior Manager signature required **prior** to presentation at SMAT.

Department	<input type="text"/>	Date	<input type="text"/>	Requestor	<input type="text"/>	Ext #	<input type="text"/>
Item Description	<input type="text"/>						
Manufacturer Name & Catalog #	<input type="text"/>	HPG Contract #	<input type="text"/>				
Vendor Agreement Signed	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unit of Measure	<input type="text"/>	Each Price \$	<input type="text"/>		
Other Vendor Available	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, their cost \$	<input type="text"/>	Name	<input type="text"/>		
Old Item	<input type="text"/>	Catalog #	<input type="text"/>	Unit of Measure	<input type="text"/>	Each Price \$	<input type="text"/>
Will the old item be deleted from inventory	<input type="checkbox"/> Yes <input type="checkbox"/> No	FDA Approved	<input type="checkbox"/> Yes <input type="checkbox"/> No				
What will happen to the current inventory that you have in your area	<input type="text"/>						
Service/Specialty	<input type="text"/>	Physician	<input type="text"/>				
Vendor Sales Rep Name	<input type="text"/>	Vendor Sales Rep Phone Number	<input type="text"/>				
For what types of Procedures/Surgeries will product be used	<input type="text"/>						
Will the product be used on inpatients, outpatients or both (give % of usage)	<input type="text"/>						
How many of these procedures were performed during previous 12 months	<input type="text"/>	How many cases will use the new product	<input type="text"/>				
What sub account G/L number will be used	<input type="text"/>	What do you want your par qty to be min	<input type="text"/>	and max	<input type="text"/>		
Projected Annual Savings \$	<input type="text"/>	Additional Annual Cost \$	<input type="text"/>	Capital Related	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Department Director Signature:	_____			Date:	_____		
Comments: *If all of the above information is not complete and a senior manager Pre-SMAT signature is not below. The form will be returned to you for completion.							
CPT Code / DRG Code	<input type="text"/>	CRD Recommendation	<input type="text"/>	Date Received by CRD	<input type="text"/>		
Applicable Senior Manager Pre-SMAT Review and Recommendation _____							Date _____
SMAT Team Recommendation: <u>Recommend</u> or <u>Do not recommend</u> procurement of this product or service (circle one)							
Date: ___/___/___ _____							(signature/title)
SMAT Comments: _____							

DEFINITIONS FOR NEW PRODUCT REQUEST DATA SHEET

Department – List department name.

Date – Date form completed by Requestor.

Requestor – Contact person for additional information.

Ext # - Telephone extension of Requestor.

Item Description – New product's name.

Manufacturer Name & Catalog # – New product's manufacturer and catalog number.

HPG Contract # - HealthTrust Purchasing Group contract number.

Vendor Agreement Signed – If not, copy of vendor agreement should be provided.

Unit of Measure – Represents how supply will be charged to patient (ex. each, pack, etc...).

Each price \$ – Cost per unit of measure.

Other Vendor Available – Other HPG contracted vendor available.

If yes, their cost – Their cost per unit of measure.

Name – Other vendor's name.

Old Item – If new product is replacing a current product, give current product's name.

Catalog # – Current product's catalog number.

Unit of Measure – Represents how supply is charged to patient for current product.

Each Price \$ – Cost per unit of measure for current product.

Will the old item be deleted from inventory – Product that will be consumed or returned and not replaced if new item is approved.

FDA Approved – Is product approved by the Federal Drug Administration for use on human patients. If product is in a trial phase, then the answer is no.

What will happen to the current inventory that you have in your area – How current inventory will be consumed or disposed of.

Service/Specialty – Hospital product line name (ex. Neurosurgery, Outpatient Physical Therapy, etc...).

Physician – Last of physician(s) that will utilize product.

Vendor Sales Rep Name – Name of representative for manufacturer.

Vendor Sales Rep Phone Number – Phone number of representative for manufacturer.

For what types of Procedures/Surgeries will product be used – List most common procedures new product will be used for.

Will the product be used on inpatients, outpatients, or both (give % of usage) – List percentages for product utilization on inpatient or outpatient services.

Complete only one of the following questions:

How many of these procedures were performed during the previous 12 months – Identify the number of times the old item was used. Data sources could be SMART – purchases for the last 12 months, number of times item was charged based on Hospital Procedure Analysis, and/or data analysis pulled by decision support services.

OR

How many cases will use the new product – An estimation of use for the new product that facility has no history on.

What sub account G/L number will be used – This is the 3-digit Host G/L supply expense sub account number. Contact Materials Management or Accounting with any questions.

What do you want your par qty to be min/max – Minimum and maximum amount of supply items on shelf. These parameters will be used to setup minimum and maximum in SMART.

DEFINITIONS FOR NEW PRODUCT REQUEST DATA SHEET (continued)

Complete only one of the following questions:

Projected Annual Savings \$ – Take the price differential between the old and new product and multiply by the previous 12 months utilization.

OR

Additional Annual Cost \$ – Take the new product cost and multiply by the estimated utilization.

Capital Related – Is this supply to be used with a new piece of capitalized equipment.

Department Director Signature – This signifies approval of Department Director.

Date – Date approved by Department Director.

Comments – Space to provide any additional information Requestor may want to share.

CPT Code/DRG Code – Related CPT for outpatient procedures or DRG related to inpatient services.

CRD Recommendation – Approval or denial recommendations by Clinical Resource Director (CRD).

Date Received by CRD – The date CRD received completed New Product Request Data Sheet.

Applicable Senior Manager Pre-SMAT Review and Recommendation – By signing and dating, Line Administrator approves addition of new product.

SMAT Team Recommendation – Recommend/approve or Do not recommend/deny.

Date/Signature – By signing and dating, SMAT Committee Chairperson approves addition of new product.

SMAT Comments – General comments by SMAT Committee Chairperson.