IOWA HEALTH
DES MOINES
Methodist • Lutheran • Blank

Date Prepared

Vendor Product/Equipment Introduction Request

Vendors who would like IH-DM (Methodist, Lutheran, Blank, and Methodist West Hospitals) to consider the purchase or usage of a particular product or equipment may request IH-DM's review by completing the information on this form and submitting to a System Procurement Buyer or if surgery related, to Operating Room Team Lead and/or Manager.

Vendor Information

Company Name:	Representative's Name:
Mailing Address Line 1:	Phone #/Cell/Pager#:
Mailing Address Line 2:	Email Address:

Description of Product/Equipment (and include description of type of technology)

Product Name and Description:	
Vendor Product Training Documents Attached: ☐ Y ☐ N	Are there any approvals required prior to use of this product? (credentialing, IRB, etc) ☐ Y ☐ N If yes, what approval is needed?
Will product inservicing be needed? ☐ Y ☐N If "yes" who will be providing the inservicing :	
Brochures/Product Literature Attached: ☐ Y ☐ N	MSDS Attached : ☐ Y ☐ N

Type of Request

Who are the potential users(i.e. general med/surg, ht cath, surgical, lab, etc) and have any of them already evaluated this product or equipment:
How might this new product or equipment benefit IH-DM (i.e. direct supply cost reduction, decrease procedure time, etc) Attach supporting documentation.
Does this product/technology compete with any current product/technology available in the market today? If so provide cross reference to those products.
Does this product require IH-DM to implement any clinical or procedural changes from our current practice? (i.e. different access needle needed, flush with heparin instead of saline)
Are there any FDA approvals required or pending?

Cost

Each Cost:	**IHSCS System Contract** ☐ **Y** ☐ **N**	**IHSCS Contract Number:**	**IH-DM Local Contract** ☐ **Y** ☐**N**
List and/or Attach Cost of Accessory/Disposable Products Used in Conjunction with this Product or Equipment:			
Does IH-DM currently purchase other items from your company ☐ Y ☐ N		IH-DM Vendor Certified? ☐ Y ☐ N	Received Vendor Packet? ☐ Y ☐ N

References (please provide two hospitals currently using this product /technology.)

Hospital:	Hospital:
Location:	Location:
Contact:	Contact:
Phone:	Phone:

System Procurement Use Only

Form Referred To:	Date:	Committee Referred to for Review:	Date:
STATUS:			

Attach all appropriate product literature, including substantiation of claims or copies of clinical trials/studies.
Fill this form out as completely as possible in order to assure a timely, accurate review by Value Analysis Committees at Iowa Heath – Des Moines.