

University of Texas Medical Branch at Galveston

Product Request Form

ALL Questions must be answered COMPLETELY for Value Analysis Committee (VACC) consideration.

Please type your request.

Name of Products(s): _____

Manufacturer: _____

Manufacturer Catalog #: _____

Cost of Product: _____

Please attach a cost justification for the requested product(s)

Briefly Describe this product and clinical impact (also, describe other required components/accessories if applicable):

List two (2) other manufacturers of product requested:

_____ Manufacturer _____ Catalogue# _____ List Price

A. _____

B. _____

C. _____

If no other product or manufacturer is available or acceptable, please attach Sole Source/Proprietary Justification form.

Is there a product in-house now performing the same function? YES NO

If yes, what product(s) description, manufacturer, MM# & catalog # performs the same function as the requested product?

Will the requested product(s) replace or supplement current in-house product(s) now performing the same function?

YES NO

If NO, why is it necessary to introduce and use this new product?

What improvements to patient care and/or cost reductions are anticipated?

What other departments(s) will use and/or be affected by this product?

Under what circumstances will this product be used?

How will this item be issued? (I.e., Ea, Bx, Pkg, etc.) _____

Will this item be stocked in the Omnicell Units?

YES

NO

What is the anticipated annual usage volume of this product? _____

Will there be additional implementation costs, such as installation, cost of education, impact on equipment? If yes, please describe:

Is the requested product(s):

Latex Free

YES

NO

Patient Chargeable?

YES

NO

Urgently Required

YES

NO

If yes, why and how soon?

Under a current contract?

YES

NO

DON'T KNOW

If yes, what contract? _____

Will the requested product(s):

Need evaluation? YES NO

If yes, would you be willing to lead the evaluation? YES NO

If the product needs to be evaluated, who needs to be involved in the evaluation:

Name: _____ Dept: _____ Ext: _____

Need medical staff notification?

YES

NO

If yes,

Name: _____ Dept: _____ Ext: _____

How did you find out about this product? (mark all that are applicable)

_____ Prior experience with product _____ Trade Show _____ Contract Review

_____ Sales rep came to department _____ Other (specify) _____

Please attach manufacturers specification, sales literature and representative's business cards.

Please disclose any special relationship with this vendor.

Signatures: **(All signatures MUST obtained)**

Requester: _____ Account # _____ Ext: _____

Department Head/Committee Chair: _____ Date: _____

Executive Director: _____ Date: _____

Agreement to Evaluate signatures of other departments using item:

Signature	Department	Estimated Usage	Approval
1. _____			
2. _____			

Reviewed by Committee: YES NO DATE

Committee Comments:

VACC USE ONLY	
Presented on: _____ (Date)	Previous Request?
Evaluate Not Evaluate	
REQUIRED FURTHER ACTION:	

Signature: _____	Date: _____

Decision:	Date:
YES Formulary Number: _____	No