Enterra® Therapy
Device Tracking Registration Form
(Neurostimulation System)

The information you provide on this form is necessary for Enterra Medical to meet Enterra Medical's government obligations regarding product safety, effectiveness and quality surveillance, including device tracking, product performance, monitoring or reporting, and is a public health disclosure under Section 164.512(b)(1)(iii) of the HIPAA Privacy Rule.

Please return completed form to Enterra Medical via the Business Reply Envelope, email to registrations@enterramedical.com or fax to 1-855-541-3367.

Patient Information

PATIENT INFORMATION

Apply patient information label if available

To send **PERMANENT** device registration card to the patient, the following information needs to be filled out

Patient Name (Last, First, Middle Initial) Birth Date

Gender: ☐ Male ☐ Female

Street Address

City, State, Zip

Phone Number and Email Address

Parent/Guardian (If Applicable)

Gastroparesis Diagnosis: ☐ Diabetic ☐ Idiopathic

SURGEON & IMPLANT FACILITY

Facility Name

City, State, Zip

Physician Name (Last, First, Middle Initial)

PHYSICIAN MANAGING THERAPY

If different from surgeon (will be listed on I.D. card.)

Physician Name (Last, First, Middle Initial)

Street Address

City, State, Zip Phone Number

IMPLANT DEVICE DATA

Fill out the Temporary Patient Identification Card and give it to your patient

Implant Date: _____

Apply Neurostimulator Label Here or Write in Serial Number

Apply Lead Label Here or Write in Serial Number

Apply Lead Label Here or Write in Serial Number

☐ Explant

☐ IPG Serial Number:_____

☐ Lead Serial Number:_____

☐ Lead Serial Number:_____

REFERRING PHYSICIAN

If different from surgeon

Physician Name (Last, First, Middle Initial)

Street Address

City, State, Zip Phone Number

PRIMARY PAYER INFORMATION

☐ Commercial:_____

☐ Medicare: _____

☐ Medicare:Advantage: _____

☐ Medicaid Managed Care: _____

☐ Other: _____

Person filling out the form:

(Name and Title) (Phone Number)