

\*\*Please complete all the information below and attach all signed chart notes and patient demographic information\*\*

Please contact Customer Service with any questions

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Male:  Female:

Address: \_\_\_\_\_ DOB: \_\_\_\_\_ HGT: \_\_\_\_\_ WGT: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Patient's Preferred Language:  English  Spanish Other: \_\_\_\_\_

Responsible / Emergency Contact: \_\_\_\_\_ Emergency Contact Phone: \_\_\_\_\_

Does the patient have a latex allergy?  Yes  No Has the patient been notified of this order?  Yes  No

Primary Insurance: \_\_\_\_\_ Policy ID # \_\_\_\_\_ Group # \_\_\_\_\_ Phone: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Policy ID # \_\_\_\_\_ Group # \_\_\_\_\_ Phone: \_\_\_\_\_

Primary ICD-10 Diagnosis Code (required):  R33.9 (retention)  R32 (incontinence)  N39.46 (mixed incontinence)

Secondary ICD-10 Diagnosis Code: \_\_\_\_\_

**PRODUCT SELECTION****INTERMITTENT CATHETERS / TRAYS** (Medicare allows up to 200 per month) Excess quantity requires special review.

Type:  Straight  Coude (chart note required)  Closed System (Two UTIs in last 12 months)

Size:  6FR  8FR  10FR  12FR  14FR  16FR  18FR Other: \_\_\_\_\_

Length:  6" (female)  10" (pediatric)  16" (adult)

Coatings:  Uncoated  Pre-lubricated  Hydrophilic  Red Rubber

Frequency:  1x/day  2x/day  3x/day  4x/day  5x/day  6x/day Other: \_\_\_\_\_ Quantity: \_\_\_\_\_

**MALE EXTERNAL CATHETERS** (Medicare allows up to 35 per month) (MA allows up to 30 per month) Excess quantity requires special review.

Size: \_\_\_\_\_ MM Quantity: \_\_\_\_\_

**FOLEY CATHETER** Size:  12FR  14FR  16FR  18FR  Coude'Insertion Tray Size:  5cc  10cc  30cc**ACCESSORIES**

<input type="checkbox"/> Irrigation Tray (Non Routine Irrigation) Medical Records Required Quantity: _____	<input type="checkbox"/> Cunningham Clamp Quantity: 1 every 3 months
<input type="checkbox"/> Bedside Bag (2000ml) (Pick 2 of the same item or 1 of each, 2 max.) Quantity: _____	<input type="checkbox"/> Foley Velcro Cath Holder Quantity: 1 / month
<input type="checkbox"/> Leg Bag <input type="checkbox"/> 500ml <input type="checkbox"/> 1000ml Quantity: _____	<input type="checkbox"/> Anchoring Device 12 per month (Catheter Secure) Quantity: _____
<input type="checkbox"/> Lubricant Packets Quantity: _____	Other: _____ Quantity: _____

**REFERRAL INFORMATION**

Office Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact: \_\_\_\_\_ Email: \_\_\_\_\_

How would you prefer to be contacted:  Phone  Fax  Email

BY SIGNING BELOW, I AUTHORIZE the use of this document as an order and I certify that the above prescribed supplies are medically necessary and reasonable. I will maintain an original signed and dated copy of this order in my medical records.

Ordering Clinician or Physician: (Please Print): \_\_\_\_\_ MD#: \_\_\_\_\_ NPI: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Duration of Need: \_\_\_\_\_ (# Months) Start Date: \_\_\_\_\_ # of Refills: \_\_\_\_\_