



Urological & Incontinence Supply Order Form

Rep: Nick Domanovich
 Email: Referrals@activelifemed.com
 Fax to: 209-926-9231
 Phone : 800-319-2336

Attach patient demographics and chart notes.

Patient Name: _____ Phone: _____ DOB: _____
 Address: _____ **Latex Sensitive:**
 Primary Insurance: _____ Yes No
 Secondary Insurance: _____ Order Date: _____ Male Female

Primary Diagnosis: _____ **Secondary Diagnosis:** _____
 R33.9 Retention of Urine, Unspecified
 R32 Unspecified Urinary Incontinence

INTERMITTENT URINARY CATHETERS: The following products are required for continued use

French Size: _____ Length of Need: _____

Include lubricant packets Include insertion supplies

Straight tip Coude tip: *The patient is unable to pass a straight tip catheter*

Closed System: The patient has a history of UTIs (Attach cultures and labs)

I confirm the patient has consented to receive product samples and enroll in a manufacturer education program.

Notes: _____

Frequency & Quantity:
 1x/day 30/month; 90/90 day
 2x/day 60/month; 180/90 day
 3x/day 90/month; 270/90 day
 4x/day 120/month; 360/90 day
 5x/day 150/month; 450/90 day
 6x/day 180/month; 540/90 day
 7x/day 210/month; 630/90 day
 Other

ADDITIONAL PRODUCTS:
 Diagnosis: _____

Male External Catheters: SM MED LG XL Qty/day _____ Qty/30 _____ Qty/90 Day _____

Foley Catheter: French Size _____ Include Insertion Tray 1/mo; 3/90 day

Leg bags: 500 mL 1000mL 2/mo; 6/90 days Bedside Bags 2000 mL 2/mo; 6/90 day

Incontinence: Medical condition/diagnosis causing bowel or bladder incontinence: _____
 Type of urinary or bowl incontinence: _____

	QTY/MONTH	SIZE/TYPE	FREQUENCY(#/24hrs)	REFILLS
Briefs	_____	_____	_____	_____
Pullups	_____	_____	_____	_____
Liners/Boosters	_____	_____	_____	_____
Underpads	_____	_____	_____	_____
Wash	_____	_____	_____	_____
Creams	_____	_____	_____	_____
Gloves	_____	_____	_____	_____
Waterproof Sheeting	_____	_____	_____	_____

Facility: _____ Address: _____
 Phone: _____ Fax: _____ Email: _____
 HCP _____ NPI _____ HCP _____ NPI _____

Prescription Physician's Verification
 I have reviewed my patient's records and items requested above. I verify that I have physically examined the patient within the last 12 months, and have established that his patient has a chronic pathologic condition that is causally related to his/hear incontinence. I authorize the items described above as medically necessary for the patient. I will maintain a copy of this prescription in the recipient's.

Prescriber Signature: _____ Date: _____

Prescriber acknowledges that by signing this order form, he/she is 1) acting in the capacity that meets all state prescribing requirements based on license capacity; and 2) authorizing fulfillment of this supply order by Active Life Medical Inc. and any of its affiliates. This document contains privileged and confidential info intended only for the use of the addressee(s) listed. If you are not the intended recipient of this document, you are hereby notified that any dissemination or copying of this document is strictly prohibited. If you have received this document in error, please notify us immediately by telephone (800-319-2336) and return the original via the US Postal Service, to Active Life Medical Inc. 4217 Coronado Ave. Unit D Stockton, CA. 95204.