Urological & Incontinence Supply Order Form

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Attach patient demographics and chart notes.

Patient Name: _____ Phone: _____ DOB: _____

Address: _____ **Latex Sensitive:** ☐Yes ☐No

Primary Insurance: _____

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: _____