Doctors Order

Fax: 877-455-2558

Phone: 877-424-2562

PATIENT INFORMATION (Please print)

Patient Name:_______________________________________SS#:_______________ DOB:____________

Address:____ Male Female

City:______________________ State: ______ Zip:_________ Telephone:_________________________

Responsible Party: _____________________________ Telephone:____________________

Emergency Contact: ____________________________ Telephone:____________________

Caregiver: ___________________________________ Telephone:____________________

INSURANCE INFORMATION

Primary Ins:______________________________________

ID #:_______________ Telephone #:_______________

Secondary Ins: ____________________________________

ID #:_______________ Telephone #:_______________

REFERRING AGENCY______________________

Referring Agency: _____________________________

Nurse:______________ Telephone #:_____________

Is patient being seen by Home Health Agency: ☐ Yes ☐ No

DISCHARGE DATE _____/_____/_____

PRIMARY DIAGNOSIS (required) ☐ Permanent Urinary Retention 788.20 ☐ Permanent Urinary Incontinence 788.30 ☐ Other ______________

SECONDARY DIAGNOSIS ☐ Urinary Tract Infection 599.0 ☐ Paraplegia ☐ Spina Bifida ☐ Neurogenic Bladder 596.54 ☐ Quadriplegia ☐ Other ___________

Duration of Need _______ months (99 = Lifetime) Does the patient have a latex allergy? **Yes** **No**

***Answer for INTERMITTENT CATHETERIZATION ONLY**

1. Has patient performed self intermittent catheterization?
   ☐ **Yes** ☐ **No**
2. Does the patient have chronic/permanent urinary incontinence or retention? **Yes** **No**
3. Number of catheterizations per 24 hrs: ____
4. Does patient have a history of urinary tract infection? ☐ ***Yes** ☐ **No**
   *If yes, fax a copy of clinic notes on urine

CATHETERS

☐ **Intermittent Urinary Catheter**

☐ **Coude Intermittent Urinary Catheter**

Mark Appropriate Justification – Must choose one for coude

☐ BPH w/ obstruction ☐ Strictures ☐ False Passage ☐ Scar Tissue

☐ Other: ________________________
(please supply documentation)

☐ **Closed System Catheter Kit**

☐ **Male External Catheter** Size: _______________

☐ **Foley Catheter** Type: _______________

☐ **Insertion Tray** ☐ **10cc** ☐ **30cc**

☐ **Other:** ______________________________________

DRAINAGE BAGS

☐ **Leg Bag __500ml __750ml __1000ml**

☐ **Bedside Bag __500ml __750ml __1000ml**

☐ Other ____________________ Quantity: __________

French Size: ________________

Quantity: ________________ **(per month)**

Frequency of Change:________________ **(per day)**

Lubricant: ____Packets ____Tube

MANUFACTURER: ___________________

Use This Area for Comments:______________

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I certify that this patient is currently under my care and the prescribed equipment or supplies are reasonable and medically necessary. All information on this form is accurate. By my signature below, I (physician or non-physician healthcare provider) authorize the use of this document as a legal prescription.

Ordering Physician ______________________________________ **Tel**__________________**Fax** _______________

Address ____

Physician Signature _____________________________________ **Date**: _______________ **NPI #** _______________