

Patient Information

First Name: _____ Last Name: _____
 DOB: _____ Phone Number: _____ Email: _____
 Address: _____ City: _____ State: _____ Zip Code: _____

NOTE: Please Include Patient Demographics Page

Insurance

Primary: _____ Policy/ID #: _____ Group# _____
 Secondary: _____ Policy/ID #: _____ Group# _____

Dispensing

Order Date: _____

Diagnosis

Primary: ☐ R33.9 Retention of Urine ☐ R32 Urinary Incontinence

☐ Other: _____

Secondary: _____

All diagnosis provided must be supported in patient's recent medical records.

Does the Patient currently have Chronic or Permanent Urinary Incontinence or Retention not to be corrected in the next 90 days?

☐ Yes ☐ No **NOTE: Please include patient progress notes**

Ordered Supplies

Intermittent Catheters	Brand/Item	French Size	Frequency per Day (Required)	
☐ Intermittent Urinary Catheter		☐ 8 FR	☐ 2 per day/60 month/180 per 3 months	
☐ Intermittent Urinary Catheter: Coude Tip		☐ 10 FR	☐ 3 per day/90 month/270 per 3 months	
☐ Intermittent Urinary Catheter with Insertion Supplies		☐ 12 FR	☐ 4 per day/120 month/360 per 3 months	
☐ Straight ☐ Coude Tip		☐ 14 FR	☐ 5 per day/150 month/450 per 3 months	
		☐ 16 FR	☐ 6 per day/180 month/540 per 3 months	
		Other _____	☐ Other _____	
Urological Items	Brand/Item	Sizing	Quantity/Month	Frequency of Use
Male External Catheters ☐		Select MM	Select	N/A
Leg Bag ☐ Bedside Drainage Bag ☐		N/A	Select	N/A
Foley Catheter ☐ Two-way ☐ Three-Way ☐ Latex ☐ Silicone		Select FR	Select	N/A
Foley Insertion Trays ☐ w/bag ☐ w/o bag		Select cc	Select	N/A
Lubricant ☐ packets ☐ tube		N/A	Select	N/A
Other _____				

PHYSICIAN ATTESTATION:

I certify with my signature that I am the physician named below. The information contained on this Written Order is true and complete to the best of my knowledge. This patient was evaluated by me and treated for the condition as stated above. The patient's medical record accurately contains documentation to support medical need and utilization of the supplies prescribed by me. This order for supplies is reasonable and necessary for the diagnosis and treatment of the patient's illness. The patient and or caregiver has been trained on the proper use of the supplies and is capable of following these instructions. A copy of this signed order will be maintained on file as part of the patient's medical record and made available to Medicare or other

PHYSICIAN NAME: _____ NPI # _____ PHONE # _____

Physician Signature: _____

Instructions for Referral Submission

Fax or email completed form along with the documents listed below

- Patient Face Sheet (containing current demographics and insurance)
- Medical Record (must include Diagnosis codes) with in last 30 days that confirms need for supplies based on condition