MaxWell MEDICAL SERVICES

Prescription Form

Detailed Written Order — Urological Supplies

P **1-800-881-7215** | F **1-866-728-9338**

PATIENT INFORMATION

Patient Name _____ DOB _____

Address _____

Phone _____ Email _____

Please attach patient demographics and progress notes supporting the order details. Thank you.

DIAGNOSIS

☐ Retention of Urine (R33.9)

☐ Urinary Incontinence (R32)

Permanent urinary retention or urinary incontinence (expected to last greater than 90 days) ☐ Yes ☐ No

☐ Other Diagnosis _____

ORDER DURATION

Start Date _____

Length of Need/Refills (months)

☐ 99 (lifetime)

☐ 12

☐ Other _____

PRESCRIBED SUPPLIES

☐ Intermittent Urinary Catheter Straight Tip (A4351)

☐ Intermittent Urinary Catheter Coudé Tip (A4352)

☐ Intermittent Urinary Catheter with Insertion Supplies (A4353) ☐ Coudé Tip

☐ Sterile Lubricant Packet (A4332)

☐ Other _____

Frequency (times/day) _____

Quantity (number/month) _____

French Size _____

Length ☐ Male ☐ Female ☐ Pediatric

CLINICIAN INFORMATION

Clinician's Name _____

Office Name _____

Phone _____ Fax _____ Sent by _____

Clinician's Signature (No Stamps) _____

NPI # _____ Date _____

SUBMISSION

Fax **1-866-728-9338**