

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
- ☐ Latex Allergy
- ☐ Other Diagnosis _____

ORDER DURATION

- Start Date _____
- Length of Need/Refills (months)
- ☐ 99 (lifetime)
- ☐ 12
- ☐ Other _____

PRESCRIBED SUPPLIES

- ☐ Intermittent Urinary Catheter Straight Tip
☐ A4351 Uncoated ☐ A4295 Hydrophilic
- ☐ Intermittent Urinary Catheter Coudé Tip
☐ A4352 Uncoated ☐ A4296 Hydrophilic
- ☐ Intermittent Urinary Catheter with Insertion Supplies
☐ A4353 Uncoated ☐ A4297 Hydrophilic ☐ Coudé Tip
- ☐ Sterile Lubricant Packet A4332 ☐ 4oz Tube Lubricant A4402
- ☐ Other _____

FREQUENCY & QUANTITY

- 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