PHYSICIAN'S ORDER FOR
UROLOGICAL or INCONTINENCE SUPPLIES

614 E Altamonte Dr
Altamonte Springs, FL 32701
Phone: 407-849-6455
Fax: 407-849-6458

EFFECTIVE DATE: ___/___/______

Patient Information:

Name: ______________________________________

Address: ______________________________________

City/State/Zip: ________________________________

Phone: (____) ______________ **DOB:** ______________

Physician Information:

Name: ____

Address: ______________________________________

City/State/Zip: _________________________________

Phone: (_____) ___________ **Fax:** (____) ____________

NPI: ________________ **License #:** _______________

DIAGNOSIS INFORMATION

Primary Diagnoses:
Secondary Diagnoses:
Other:

Length of need: _______ **Months**

Prognosis:

Has the patient suffered UTIs in the last 12 months?

Urological Catheters

French Size:_____ Balloon Size_________ Quantity Per Day________

Catheter Type

- Intermittent Catheter
- Foley Catheter
- Closed System Catheter Kit
- Red Rubber Catheter
- External Condom Catheters

Accessories:

- Coude Tip
- Hydrophilic
- Leg Bags
- Night Bags
- Lubrication Jelly
- Latex Gloves

Brand Name *(patient preference unless specified)*_________________

Most Common: Quantity = 200 per month Coloplast Self-Cath Intermittent Catheter
Quantity 4 1000ml leg bags
Lubrication Jelly

Incontinence Supplies

Adult:

- Adult size Brief/Diaper
- Adult size Protective underwear Pull on
- Bariatric Size Brief/Diaper

Pediatric:

- Pediatric size Brief/Diaper
- Pediatric Size Prot Underwear Pull on
- Youth Size Brief/Diaper
- Youth Size Prot Underwear Pull on

Under Pads/Chux

- Disposable Liner/shield Pad
- Reusable

BY SIGNING BELOW, I AUTHORIZE the use of this document as a legal prescription, and I certify that the above prescribed equipment is medically necessary and reasonable and is not being prescribed for convenience. I will maintain an original signed copy of this order in my medical records and make it available to Medicare, their authorized agents or other insurer, if required. I have instructed my patient that you will be contacting them to complete their order.

X________________________________ ______________________ ______________________________

Physician Signature *Date* *NPI*