PHYSICIAN'S ORDER FOR UROLOGICAL SUPPLIES

EFFECTIVE DATE: ___/___/______

915 S Orange Ave
Orlando, FL 32806
Phone: 407-849-6455
Fax: 407-849-6458

Patient Information:

Name: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

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

Physician Information:

Name: ______________________________

Address: ______________________________

City/State/Zip: ______________________________

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

NPI: ________________ **License #:** ______________

All Sections must be completed. Please sign and date any changes you make to this information.

DIAGNOSIS INFORMATION

_____ Permanent Urinary Incontinence 788.30

_____ Permanent Urinary Retention 788.20

_____ Urinary Obstruction 599.6

_____ Neurogenic Bladder 344.61

_____ Abnormal Urination 788.69

_____ Paraplegia 344.1

_____ Quadraplegia 344.09

_____ SpinaBifida Mutliple Sclerosis 741.0

_____ Other (specify code) __ __ __ . __ __

Length of need: ***Lifetime unless specified***

______________ **Months**

Prognosis: ____ **Good** ____ **Fair** ____ **Poor**

Wt. ____________**lbs.** **Ht.** _____________**in.**

Has the patient suffered from UTIs in the last 12 months? ____ Yes ____ No

If yes, how many? ___________________________

NOTES:

Physician please note: No product authorized herein will be supplied without the consent of the patient.

QTY/MO	SIZE	DESCRIPTION	QTY/MO	SIZE	DESCRIPTION
		Intermittent straight catheters			Leg bags
		Intermittent coude catheters			Leg bags strap - fabric
		Intermittent hydrophilic catheters			Extension tubing
		Intermittent closed system w/insertion supplies			Catheter holder - fabric
		Foley catheter insertion trays			Sterile lubricating packets
		Foley catheter insertion trays w/ Foley catheter			Non-sterile lubricant - tube
		Irrigation trays			Tape - roll
		Male external Catheters			Gloves
		Night bedside drain bags			Other -

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.

X ______________________________ ______________________ ______________________________

Physician Signature *Date* *NPI*