

**PHYSICIAN'S ORDER FOR  
UROLOGICAL SUPPLIES**



724 S US Hwy 441  
Lady Lake, FL 32159  
Phone: 800-747-0246  
Fax: 888-849-6456

EFFECTIVE DATE: \_\_\_/\_\_\_/\_\_\_

**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 Mutiple 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*