

**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 #:** _____

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

DIAGNOSIS INFORMATION

Please check all pertinent diagnoses

- ___ 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
- ___ Quadriplegia 344.09
- ___ SpinaBifida Multiple Sclerosis 741.0
- ___ Cerebral Palsy 343.9
- ___ Dysuria 788.1
- ___ Renal Colic 788.0
- ___ Other (specify code) ____ . ____

Length of need: *Lifetime unless specified*

_____ Months

Prognosis: ___ Good ___ Fair ___ Poor

Wt. _____ lbs. **Ht.** _____ in.

Waist Size _____ **Hip Size** _____

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			Adult size Brief/Diaper
		Intermittent coude catheters			Adult size Protective underwear Pull on
		Intermittent hydrophilic catheters			Pediatric size Brief/Diaper
		Intermittent closed system w/insertion supp			Pediatric Size Prot Underwear Pull on
		Foley catheter insertion trays			Youth Size Brief/Diaper
		Foley catheter insertion trays w/ Foley cath			Youth Size Prot Underwear Pull on
		Irrigation trays			Disposable Liner/shield Pad
		Male external Catheters			Bariatric Size Brief/Diaper
		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